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PUBLIC HEALTH NURSING

VOL. 41, NO. 1 JANUARY 1949

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PUBLIC HEALTH NURSING

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The National Organization for Public Health Nursing is a membership organization composed of individual and agency members. Its purpose is to serve as a clearing house of information, and to develop and interpret standards for personnel and practices in public health nursing. This is accomplished through an advisory service to individuals and agencies interested in public health nursing; through publications, including the official magazine PUBLIC HEALTH NURSING, and through connections with national, state, and local agencies in related fields. The organization is administered by an elected board of lay and professional members. Its activities are carried on by committees representing public health nursing and related fields, and by an employed staff.

The organization has no jurisdiction over its membership. It serves in a purely advisory capacity. The acceptance of any of its recommendations is entirely voluntary.

Membership—Nurse, $5; General, $5; Sustaining, $10; Life, $100. Agency—Full dues 1% of annual expenditures for public health nursing service. Associate agency, $10.

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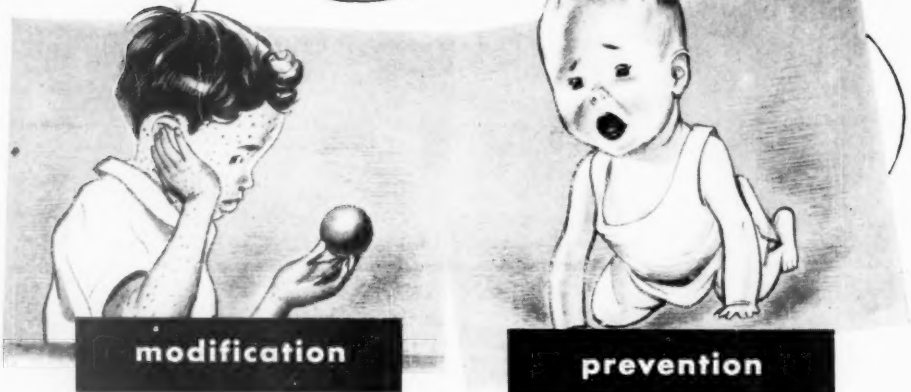

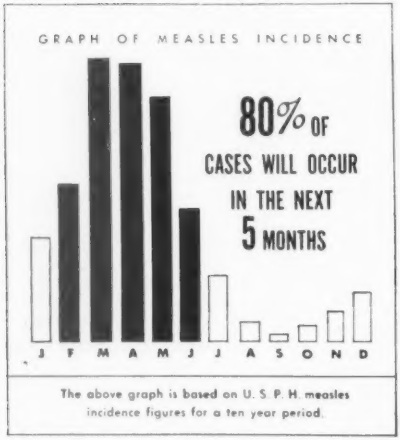

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PUBLIC HEALTH NURSING

Official Organ of the National Organization for Public Health Nursing, Inc.

SOUND INVESTMENT FOR 1949

A PRELIMINARY count at the end of the year showed that a total of 3,225 members, old and new, nurse and non-nurse, have been enrolled in the NOPHN for the calendar year 1949. Many more of you have preferred to wait until after the holidays to send in your membership dues. We anticipate, therefore, that as you read this, the above figure will have reached at least 5,000.

This is a good beginning and we are happy at the ready response our call for early enrollment has received. But we all realize that 5,000 members can be considered only a beginning. The sober fact is that, taking into consideration all available sources of income including reserves, NOPHN must have the support of at least 10,000 individual members in 1949 in order to maintain its present program of service. Thus, the figure 10,000 becomes the imperative "X" in all our membership calculations—a minimum which must be met.

But are you satisfied with only a minimum membership for your national organization? Is there any reason why we cannot increase the 10,000 by two, three, or four thousand? Is there any reason why, working together, we cannot achieve a membership figure which will make it possible for NOPHN to extend its program to include such important projects as the study of local public health nursing administration, combination agencies, changing caseloads,—to extend the activities of NOPHN's specialty sections—to give increased assistance to individual members in solving their specialized problems—to insure a strong and forceful role for public health nursing in the current nationwide movement for improved nursing care and education—to give added service in all other fields where it is urgently needed?

We believe there is no reason why NOPHN membership cannot be substantially increased. The membership potential is there—with more than 22,000 public health nurses employed in the United States, and with additional thousands of board and committee members helping in the work of local public health nursing agencies. To the latter the national program is just as important.

This year our aim is to invite to NOPHN membership every public health nurse, every person interested in public health nursing who is not yet affiliated with the organization.

Leading this work are two long-time members—Mrs. Olive W. Klump, national nurse membership chairman, and Mrs. Carl B. Grawn, national general membership chairman.

To assist Mrs. Klump, many of our busiest nurse members have accepted appointment as state nurse membership representatives.

Responding to an appeal from Mrs. Grawn, the Executive Committee of the Board and Committee Members Section voted unanimously and enthusiastically to adopt promotion of general membership and interpretation of the NOPHN program as the Section's major project for 1949.

With leadership like this, we should indeed "move mountains"—but we cannot leave the whole job of membership to leaders alone. The help of every individual member of NOPHN is needed.

Those of you who have taken full advantage of your membership know that your national organization gives much in return for your membership dues.

You know that through NOPHN, standards of procedure and practice have been established so that the day-by-day performance of public health nurses can be in line with modern scientific knowledge. Through NOPHN accreditation activities, more and more colleges are offering sound preparation for public health nursing. Through NOPHN studies, steady improvement has been made in the policies that directly affect hours of work, salaries, vacation, sick leave and advancement of public health nurses. Through PUBLIC HEALTH NURSING and other NOPHN publications every member can readily keep informed on new trends in medicine and public health, current opinions and developments in the public health nursing field.

You know that through your vote, you have a voice in the national planning that shapes public health nursing's future. You are part of an organization nationally recognized for its leadership in the development of the best possible public health nursing for all people in every community.

Add to these the following very practical membership privileges: free copies on request of magazine reprints; *Phn*, NOPHN'S quarterly news bulletin; use of the National Health Library; use of NOPHN Loan Folders; and a special saving of $1 a year on your magazine subscription—add all these and it can readily be seen that NOPHN membership is a very sound investment indeed.

If you yourself have not renewed your membership for 1949, will you do so without delay? Will you help us interpret the work of NOPHN to your friends and co-workers? Will you make it your responsibility to bring at least one new member into NOPHN this year?

NFIP CONTRIBUTES TO NURSING

THE VALUE of special preparation in orthopedic nursing is recognized and accepted. The patient with poliomyelitis, those with physical handicaps and long term illnesses require special nursing skills founded on precise knowledge.

The National Foundation for Infantile Paralysis granted funds to the National Organization for Public Health Nursing in 1939 to enable that organization to study desirable preparation for nurses in this field and to provide advisory service to public health nurses in the prevention of unnecessary crippling and in the care of patients with orthopedic disabilities.

This project was broadened a year later to include hospital nursing personnel and hospital services. The National Foundation approved a grant to the National League of Nursing Education, and the Joint Orthopedic Nursing Advisory Service,—a joint project of NOPHN and NLNE—was inaugurated in October 1941. This grant made scholarships available to assist nurses in both hospital and the public health field in securing advanced preparation in orthopedic nursing. As of October 1948, 110 awards have been made. Seventy-six of the 91 who completed their studies are occupying positions of leadership in 23 states, Territory of Hawaii, District of Columbia, and on the staffs of 4 national organizations.

The services available from JONAS include: field advisory service of five consultants to schools of nursing and public health agencies; help in program planning; preparation and distribution of educational materials—handbooks, reprints, visual aids (slides, films, exhibits); counseling through correspondence and personal interviews; assistance in regard to correlation of nursing and physical therapy needs in epidemics of infantile paralysis.

The Joint Orthopedic Nursing Advisory Service from its inception has been supported entirely by annual grants from the National

(Continued on page 35)

THE AMERICAN FAMILY

A sociologist looks at the family and tells what has happened and what is going to happen to it

REUBEN HILL

WHEN WE SPEAK about the American family we are talking about an abstraction since there are some thirty-seven million family units in our country. We have a number of sources to turn to to give us a picture of what these families are like and what is happening to them today, an important source being the insights of editors, writers, and ministers who are very sensitive to the changes in our present world.

Wrote one editor:

> In America family living is no longer compulsory. A man gets his meals cooked and his clothes mended rather more cheaply without a wife than with one. Most women can provide themselves with better clothes through their own efforts than out of the pay envelope of a husband. Economically, marriage has ceased to be a necessity and has become a luxury. Most couples live more frugally together than they did separately. They have to economize to marry.

And if they have children, there is even more economizing.

The dean of a graduate school writes:

> American life is no longer family centered. Urban life today is built about the individual, not the family unit. The social life is for the pair, not the family. To find husband, wife, and children at a social gathering one must go to some remote rural area. Urban society is stratified by age groups. In the long range of man's experience, children have been considered the natural fulfillment of marriage, barrenness a marital tragedy, to have one's quiver full of arrows a blessing. No longer is this true. Some marry with no intent of ever having children, and to have one, two, or three children at the most is the nearly universal upper limit of family aspiration.

A foremost authority on the family, Dr. E. W. Burgess, writes:

> The American family approximates the concept of the family as a companionship which embodies the ideals for the preservations of which we have waged this war—of democracy as the way of life, of the equality of men and women, and of personality as the highest human value. This emerging family is dynamic, creative, and adaptable—characteristics suited for survival and growth in a society of rapid social change.

And then, finally, I want to cite a modern Jeremiah, Dr. Carle Zimmerman of Harvard. He sees nothing pretty about the state of the American family. He writes:

> The Western family is rapidly approaching its third violent crisis. The climax will be reached before the end of this century. It is already upon us in extremely high rates of all the symptoms of family decay—divorce, childlessness, disloyalty of family members to each other, and the unwillingness of many persons to burden themselves with families. Even heterosexuality is being challenged. This development of anti-familism is associated with a changed system of social relations in which more and more human behavior is based on willed contract, compulsion, and temporary selfish interest, rather than on family feeling and the voluntary willingness of persons to carry on their daily social duties.

Are all these views compatible. Is it possible they are all true?

Another source of information to which we can turn for clues about what is happening to the American family is the United States Census. Here, too, we perceive many paradoxes. Marriage in America has never been more popular, nor have decisions to divorce been more numerous. Iowa's divorce rate in 1946 was one divorce for every 3.1 marriages

Dr. Hill is associate professor of sociology, Iowa State College, Ames, Iowa.

The country as a whole had one divorce for every 3.6 marriages. Iowa, a relatively rural and heretofore regarded as a relatively stable state, had a higher rate of divorce than the country as a whole. Wishful thinkers might take some comfort in the fact that in 1945 there was one divorce per 2.7 marriages in Iowa. All these figures mean, however, is that the marriage rate was higher in 1946 in comparison with the divorce rate, so that we can make our divorce rate lower if we just encourage marriage. No solution, really!

Who are most likely to divorce in Iowa? We wish we knew. We don't even collect statistics about the divorce. All we know is that people divorce. We know nothing about their educational level, nothing about their religious affiliation, nothing about their preparation for marriage, nothing about their economic level. People who divorce register it, and the state collects no further statistics on it.

The only clue we have concerning the source of divorce in Iowa comes from a recent study of migration which showed that migrants who were veterans were five times as likely to have changed their marital status in the last year as were non-veteran migrants.

Another source of information concerning the American family is the Bureau of Vital Statistics. Its figures reveal that birth rates are currently higher than at any point since 1921, and still there are nearly a half million abortions a year, 80 percent of which are from married women. Oddly enough the percent of couples who are childless is also the highest since 1921.

Who, then, are having the babies? Those who are most able? Those who have the most money or the most education? Hardly. It would seem that only those who don't know any better or who, for some peculiar reason, stick to the old values are having the families today. People are penalized in our country for having children, penalized economically. Mobility is cut down and thereby freedom to move, to take advantage of opportunity, and the terrific costs of rearing children have not lessened any with inflation. So people who are on the make, who are out to succeed, who are out to get the good life as pictured in the magazines, the advertisements, and in our current movies are having fewer children.

Another contrast is this: Child abandonment and neglect are paralleled in America by lengthy lists of applicants for babies at adoption agencies. There just aren't enough unwanted babies produced to satisfy the demand.

There is a noticeable trend toward premarital sex experience for both men and women. The three most striking studies in that respect seem to indicate that somewhere between 60 and 85 percent of all men of marriageable age have experienced premarital sex relations, and somewhere between 30 and 40 percent of the women. Oddly enough, these figures are matched by a singularly high marriage rate. In fact we have one of the highest marriage rates of any country as well as one of the lowest rates of illegal cohabitation or of common-law marriage. In America people bother to marry, and they bother to divorce before engaging in a new union. They are amazingly legal about their immorality. They are serial polygynists.

One of the greatest sources of friction in family life today is the critical housing shortage. The number of doubled-up families has increased twofold from 1940 to 1947. The most depressing figures are from Maryland which show that 40 percent of Maryland's married youth who were studied were living with their in-laws. We prize privacy in our society, yet we force our youngsters when they marry to double-up with us. America is a land of paradoxes.

RESPONSIBILITIES OF THE AMERICAN FAMILY

A study made by Bernard in the 1930's and recently brought up to date by the White House Conference on Family Life showed that the tasks allocated to the American family by society today consisted of reproduction, protection, socialization, and affection giving. In our task of reproduction we barely pass. We have been having only 2.6 children per family, barely enough to keep us even. Currently we are doing a little better, but with a depression the number of babies born would drop immediately.

The family in its protective functions—the protection from disease, insecurity, and the providing of the essentials of food and shelter —only approximates the meeting of its needs. President Roosevelt underestimated it when he said that one third are ill-housed, ill-fed, and he might have said ill-bred.

The particular function of protection from disease is carried out as poorly as it is partly

because the services which are provided in medical care are concentrated where the dollar is rather than where the need is, so that medical services are distributed according to a pattern of dollar distribution or income distribution. In such widely dispersed areas as South Dakota, Montana and North Dakota, in areas where there are few people and few dollars, there are thousands of people without medical care of any kind. When we move across the tracks, into the slums, into the colored areas or into parts of the South where the people are poor, a shocking number of births are unattended because, although the need is great and the mortality rates for children and mothers are terrifically high, the money isn't there. The family often fails, therefore, in providing the essentials of medical care.

We do only a mediocre job when it comes to the socialization of the child. It is one of the family's functions to train the child to be honest, to be cooperative, to be moral, to be able to get along in society, to be trustworthy, not to have to resort to assault and battery to get his way. Figures seem to indicate that only somewhere in the vicinity of 30 or 40 percent of the products of our families are trustworthy. The studies of deceit and character by the Yale Institute of Human Relations support that conclusion, as do the White House Conference studies of the '30's. Who could do a better job is a nice question, but the family is failing at it.

The only function in which the family seems to have a passable record at all is the affectional function. On the personality building tasks, approximately half of our families passed creditably in the few studies that have been made. The majority of people studied claimed that they were happy, that they were enjoying their marital relationships, and that they were enjoying their parent-child relationships.

As states go, Utah would be outstanding for the number of its families that are performing their functions creditably. Utah does not have a good tax base and it does not have many resources, but it uses those resources quite effectively. In Utah you find a lower family break-up rate, a lower divorce rate, a higher percentage of children graduating from high school and college and, at the same time, a higher birth rate than in any other state of the Union. There you find a place where people are making the most of their resources and where families are large because they have been motivated primarily by the nonmaterialistic goals provided by the Mormon faith and way of life.

DIAGNOSIS OF THE AMERICAN FAMILY'S MALADY

As we come to a diagnosis of the American family's malady there are three commonplace facts which we might consider. They do furnish some clues to an understanding of its problems in these days of rapid social change.

One of these facts is that the family is a sort of funnel or bottleneck through which flows the everyday life of its members. Have you ever considered that there isn't any other institution which comes in contact with Americans every day? The church gets a proportion of them once or twice a week. The school gets them for a somewhat greater period. But the daily contacts of home are the most potent factors in shaping the life of Americans.

Another role of the family is that of the great burden carrier in our society. To our families we carry customarily our intimate and serious problems. It's here that we release our tensions, that we blow off, if you will, for home is the place where a man can be his worst, and often is! He would be fired if he acted that way on the job. He would be excommunicated if he acted that way in the church. From our families we draw the spiritual resilience, the bounce, that enables us to deal with our problems and to return to the mill refreshed and ready to take up the job again.

When I was a personnel director, I found it quite advantageous to check in on the family background of the problem person I was working with. If it were an unhappy one, I could almost predict he would become more difficult as he went along, because the family would not give him the encouragement and support that he needed after taking it from a supervisor all day.

Schmalhausen even called the family a factory for the production of lunatics. Why? Because he was a psychiatrist and he saw only the broken products of homes. I suspect that the feeling of security your family gives you, the number of burdens it carries for you, enables you to be kinder to your patients and to your coworkers.

The third fact that helps us understand the malady of the American family is that, because of its strategic position in society, it also

reflects the strains and stresses of all our institutions which are undergoing change, the church, the school, the government, and industry. All of these institutions are in a turmoil, all of them, not just the family. The family reflects the fact that the church is having its problems, that the school is in difficulty, that something is happening to industry, and that government is "going to pot." We are in a period of transition in which the family, because it is the focal point of all individuals, does reflect all the changes in these other institutions.

THE FAMILY IN TRANSITION

The truth of the matter is that the family, like society itself, is in transition from one form of living, which was relatively stable, to another. We only dimly perceive what the new way of family life is to be.

We have all kinds of families about us, and they are changing in all sorts of ways, but we can't change from one type of family life to another without undergoing disorganization. Disorganization is the price we pay for change, and it necessarily precedes, or is part of, reorganization.

In the process of reorganizing, you first have to break old habits. Have you ever tried to break one? The experience is extremely painful, particularly at first. Customs of family living are no more than group habits, and during the process of changing from one set of customs to another, instability and a feeling of being lost characterize people. The American family is in that stage now when the controls are weaker and excesses are more likely to occur.

I am not blaming or justifying the family's present condition. I am just trying to understand it with you. The family is changing, as change it must when all else in society is changing. It is changing to meet the needs of its members who must live in this hectic world. In fact one of the attributes of the family is its ability to act as a problem solving device for its members.

When household production was the main problem of the family, it resembled more a haying crew in form than a center of companionship. Today its main problem is to provide happiness and opportunities for personality growth for its members, necessitating change to a more appropriate form than that of a haying crew.

The American family we have been concerning ourselves with is a transitional family characterized by all the uncertainty but also by much of the challenge which is found in a growing, changing institution. If you have any "red blood" in your veins at all, you will like living during these times. Because you are not bound as closely by customs as your parents, you have the freedom to make creative changes and to enable your family to meet more closely the needs of its members than you would have had fifty years ago.

We are witnessing, then, the growing pains of a family which was made to order for farm life, a family which is being forced to change its form and adapt its code to the cramped quarters of cities, to migration, and to trailer life.

These adapted changes might have moved faster but for one fact: just as rural families would become adapted to urban life they would die out because they hadn't had enough children to replace themselves. So to fill their places in the factories, business, and the professions came rurally reared youngsters. They married, performed their family functions as they had been taught on the farm, which teachings made for maladjustment to city life.

Research on the farm family shows that they are still patriarchal, familistic. White House Conference studies found that the relationships between parents and children in rural areas were less harmonious than between urban parents and their children. These findings run counter to everything we feel that we know. They run counter to the statistics on juvenile delinquency. But what I suspect is that these figures reflect the difficulty which rurally reared parents living in the city have in understanding their urban reared children. We seem to be putting an overwhelming responsibility on farm families to produce stable personalities which can cope with the problems of a hectic world, and there is hope that their rapid shift to a more flexible form of family organization will help them accomplish their job.

We, then, are living participants in this period of transition, we who are parents, and our children and quite possibly their children. This explains our uncertainty in following too rigidly the patterns of our own parents. We are in transition from a tightly-

knit, patriarchal, male-dominated, adult-centered family form to a democratic, perhaps equalitarian, family in which the children are companions of the parents, where consensus is the basis of decision and where children may be heard as well as seen. We are in transition from a family interested primarily in producing food, clothes, and services to a family primarily concerned with the production of personalities.

We are in transition from a family that was held together because of the fact that the wife and children were necessary assets in a fight for survival and by the external forces of gossip and neighborhood morality to a family held together by the sheer habit of living together and by the needs of affection that are met in the home, and not much more.

Today's family is smaller. For one reason children are no longer an economic asset. The latest figures are probably much higher, but back in the late '30's it cost $10,000 for a family averaging $2,500 a year in salary to raise a youngster to the age of 18 if they didn't spend a penny on education other than the taxes they paid. Another reason for smaller families is that grandparents are less frequently a part of the family since there is no room for them and there is nothing for them to do.

Today's family has fewer rigid controls. B'ack is no longer black and white is no longer white where conduct is concerned. The old morality which was clearly defined and rigorously supported by all the decent folk in town was a far cry from the amused tolerance that greeted the quadruplets born to an unmarried mother in England a year or so ago. All the newspapers ran the stories as if the moral codes weren't even involved. We now leave morality much more up to the individual. It means, though, that the individual needs to be educated as to the consequences of immorality and here, present education comes into the picture. If you are going to withdraw the external forces to keep people straight, you will have to provide some internal forces.

Obviously the transition from autocratic to democratic control is neither complete nor comfortable. Anxious parents, remembering their own autocratic parents, can't let go of their children. They crack down and then relent too much. The problem is that we are neither willing to play the autocratic, stern disciplinary role, nor are we quite able yet to play the other role of permissiveness, letting the child go, making his own decisions, providing him with information. We are in a wilderness and we shilly-shally back and forth. Though we know we should try to bring our children up with freedom to make their own decisions, their own choices, it is an extraordinarily difficult procedure for untrained family members.

THE AMERICAN FAMILY IS A SCAPEGOAT

Another of our problems is that today's family is public scapegoat number one. Every agency and organization holds the family responsible for failures in its program. Men are found unfit for military service in their prime. Does the medical profession take any responsibility for that? No, they just report it. Did the nutritionists, the physical educators, or the schools take any of the blame? No, they all said, "If the family had done its job, we wouldn't have had this."

A relatively recent problem is that children leave school early for jobs. It is hard to keep them interested in lessons with so many money opportunities beckoning. So whom do we blame, the schools for their lack of functionality and program, their lack of vitality, or the community for its failures? No, we don't. Actually all our institutions are experiencing rocky traveling, and the family is suffering from the same cultural contradictions that are plaguing all our institutions. But the family is the most convenient scapegoat of them all.

Communities deserve all the juvenile delinquency they have. They deserve it because they are not providing necessary services either in their schools or in their recreation programs or in their churches or in their preparations for marriage for parents. It is unintelligent to humiliate and penalize parents who haven't been given any training for their job of parenthood, who live in those sections of the city which have inadequate play facilities for children. We blame and devaluate and criticize until it is a wonder parents have done as well as they have. They simply haven't had much training. The place to start is with people who are free to be trained, with youngsters today in the schools. Parents need support and training, and they need to be bolstered by people of the nursing profession as well as by school teachers and administrators and police chiefs.

In summary, the family of today is a streamlined version of its former self. It is smaller; it is less burdened with housekeeping and production of things. It is more independent, but it is also less stable. It is more democratic and altogether a more pleasant place for children to be reared, if not for adults to dominate.

The shift has been made from quantity to quality, from acres and numbers of cattle and children and stores of food in bins to quality. We have smaller families, perhaps, but better ones. That is an optimistic way to look at it—fewer children but healthier and happier ones. We are interested in producing personalities.

If these are the things that are happening to the American family, where is it heading? Those who dream of a more stable family in the immediate future are indulging in wishful thinking. Little in the current trend of social policies can be seen to point to an early solution of the basic problems which produce divorce in so high a proportion of our marriages. Family stability will have to wait upon a stable society. It will have to wait upon present and future efforts to check poorly mated persons from marrying. It will have to wait upon present and future efforts in personality testing, in measurements for marriage fitness. It is difficult to realize that we take more pains to see whether a person can operate an automobile satisfactorily, than we do for fitness for marriage and parenthood. All you have to do is swear you are not insane, feebleminded, married already, and you get a license if you can pay the fee, Well, it takes more than two dollars or so—it takes $10,000 for the first child. We need more insight into ourselves than the ability to swear we are not insane, because the insane are one set of people who don't know it.

This much needed help in mate selection will have to wait upon facilities for premarital counseling and for premarital education, and it is going to wait until other scientific devices reach the stage where they can be presented to the public with confidence and be used by a substantial proportion of our youth. I wouldn't want you to think we are in a position, if only society understood us, to provide those services today. We can't begin to provide the personnel to those few schools who see a need for it, and we are "quaking in our boots" when people do come to us, afraid we are going to do a not too good job with them.

It is doubtful whether the American family system is going to expect less of marriage in the future than it does now in the way of happiness and romantic realization. This being the case, a more complete understanding of personality and the effect of background on marriage would seem to be the way forward.

The basic cause of divorce is nothing more than marriage, unseemly marriage, poorly prepared for marriage. If society could screen out incompatibility before the wedding it would save the terrific cost in personality disintegration, the pain of husband-wife estrangements, all the unhappiness of children who don't know which parent they are to live with and who may, in addition, get placed in a home that doesn't want them. Social measures must then be devised which will come nearer to insuring that the right people marry and that each marries the right person.

Further improvement is greatly needed in helping people who are married to understand the frictions and tensions inherent in close daily companionship. The notion that people marry and live happily ever after is a fallacy and a fiction. They marry and live happily and unhappily, now and again. We need to give them greater assistance in meeting these situations with a degree of intelligence.

The American family is headed for rocky, rough roads of social changes as industry, government, and other social institutions shift and change courses. To meet these hazards more adaptable family organizations will be required. Families that are rigid, authoritarian, and fundamentalist will have trouble.

Taking the longtime view, the American family, we think, will be in sum:

More democratic than patriarchal

More affectionate than economically productive

More adaptable than rigidly loyal to family traditions and protocol

More versatile in the performance of family tasks

More person-centered than work-centered.

Adapted from an address to the Iowa State Nurses Association annual meeting, Council Bluffs, October 1947.

PUBLIC HEALTH NURSE IN DIABETES CONTROL

K. BARBARA DORMIN, R.N.

RECOGNIZING DIABETES as a public health problem, the Public Health Service of the Federal Security Agency established the Diabetes Control Section in 1946. The Section's first project was a community study of the prevalence of diabetes in Oxford, Massachusetts, the findings of which have been summarized as follows:

A diabetes mellitus study based on history, urine and blood sugar tests and dextrose tolerance tests was made by the U. S. Public Health Service on 3,516 persons in Oxford, a typical American town. This number represents 70.6 percent of the entire population of 4,983.

1. A total 70 cases of diabetes was found—40 previously known and 30 discovered during the study.

2. For every 4 previously known cases, there were 3 more hitherto undiscovered and unsuspected cases.

3. Many of the newly discovered cases reported symptoms commonly associated with diabetes, but yet were not aware of the significance of those symptoms.

An evaluation of the condition of the persons known to have diabetes indicates a need for improvement in the control of the disease by the patient.

Diabetes is much more prevalent than is commonly supposed, with large numbers of unrecognized cases in each community. Application of ways and means of discovering diabetes early by means of simple, effective tests is necessary in order that prevention may be obtained in early potential cases and that those with easily recognizable diabetes may receive adequate care early and thus escape many of the complications of this condition.

The Diabetes Section, after evaluating the results of the Oxford community survey, established units in cooperation with the health departments in Brookline, Massachusetts, and Jacksonville, Florida, to demonstrate practical means of case finding and education in diabetes control that may be used by other local health departments.

The Diabetes Demonstration Unit in Jacksonville, Duval County, Florida, was begun in February 1947 with emphasis on a case-finding program among the relatives of already known diabetic patients. The unit was begun with a public health physician, a public health nurse, two laboratory technicians, and a secretary. In May a dietitian-nutritionist was added to the staff. In setting up the unit the staff enlisted the support and cooperation of the Florida State Department of Health, the Duval County Medical Society, the health departments of Jacksonville and Duval County. The medical profession approved of the program, which included a plan for a public health nurse to visit in the homes of known diabetic patients who consented to give a list of their relatives' names and addresses, so that those relatives could be invited by letter to be tested for diabetes.

Jacksonville is a city of some 235,000 inhabitants, with about 80,000 additional residents in the rest of Duval County. The beaches, Jacksonville, Atlanta and Neptune, have a permanent population of 11,000. To call on all the known diabetics in this area would have been a slow process for the one public health nurse of the diabetes unit. To assist in the survey the city and county health department nursing offices and the Visiting Nurse Association agreed to visit one diabetic patient per nurse per week. Before the nurse began the work, it was agreed

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that a short refresher course in diabetes was necessary. There were four meetings with all the public health nurses at which Dr. Malcolm J. Ford, medical officer in charge, Anne Panessa, assistant nurse officer, and Marion E. Nichols, nutritionist, talked to the group on (1) clinical aspects of diabetes (2) nursing in diabetes (3) nutrition in diabetes. Open discussion followed.

The next step was to obtain the names of diabetic patients. The practicing physicians sent lists of their diabetic patients, but the number was small. Some diabetes specialists and the two hospitals having out-patient departments gave permission for a study of their records to obtain the names and addresses of their diabetic patients. Today the hospitals and the private physicians refer their new diabetic patients to the unit each month. With the help of all the previously mentioned, Jacksonville now has an active register of 800 confirmed diabetics. Their relatives have been invited by letter to the clinic for testing and there has been a 30-35 percent response.

Food handlers comprise another group being tested and studied. Duval County requires that food handlers renew their health cards every six months. To obtain this card a blood Wassermann test must be done. Arrangements were made to take a little extra blood for a blood sugar and to obtain a urine specimen at the same time. In all cases tested for diabetes by the unit, a history of the last time of eating and amount of food consumed prior to the test is recorded.

A good proportion of the nurse's time in the diabetes unit is spent in diagnostic follow-up. The first tests done indicate whether further tests are necessary. According to the recommendations of the medical officer, the nurse makes arrangements with the patient until the case is finally diagnosed. She must follow through to see that the patient is under medical care and treatment. Some patients, particularly food handlers, do not see the necessity or the importance of these follow-up tests because they do not feel sick. The food handlers present more problems because most of them do not have a family history of diabetes and do not know what the condition means. An educational conference is planned for each individual coming in for recheck and glucose tolerance tests, and the nature of diabetes is explained. A chart showing the blood sugar curves is used to explain the results of each test and show why further tests are necessary. A history of the patient's food intake is taken for every test. The patient is shown how the food he eats affects the amount of sugar in the blood and the nutritionist evaluates his diet.

This preliminary education gives the patient better understanding of himself and of the need for medical care and treatment. All individuals suspected of having diabetes are referred to their family or private physicians for treatment. Because of the preliminary education, the patient is better prepared to follow the recommended diet and take insulin, if prescribed by his private physician, without apprehension.

In some areas, like Jacksonville, there are no large clinics, group medical practices, or teaching facilities. Each individual doctor does not have the volume of diabetic patients to justify setting up private instruction classes nor has he the time to devote to individual instruction. Therefore, health departments rendering community service have a great opportunity to broaden that service by including education in diabetes in disease control programs.

The Jacksonville unit, as a demonstration, has set up instruction classes for diabetic patients. Four hundred fifteen persons have attended the series of six classes of two hours each. The physician gives the first lecture on the nature of diabetes. The other five classes devote an hour each to nutrition and nursing. The aim of the classes is to help the patients in self-management and control of the diabetic condition. In one class of 22 colored patients, only two were taking the prescribed dose of insulin. The others were measuring insulin inaccurately. In another class, a young white boy was complaining of "passing out" frequently. In checking with the patient it was learned that he was taught to measure 1 cc

of u.40 insulin, but was using u.80 insulin which gave him twice as much as he should have.

Diabetic patients, observed in the Jacksonville clinic, apparently have a great deal of trouble with insulin injections. Hard red spots are common rather than the exception. One middle-aged woman was taking 104 units of protamine zinc insulin. Her legs were literally covered with hard red spots. In class, the method of insulin injection was demonstrated and a chart showing the various areas where insulin might be given was shown. In talking with the patient after class, the nurse suggested that she use the upper portion of the abdomen for injections. This same woman came into the office recently. Since she began using different sites for injection of insulin, her legs have cleared up, and her dosage of insulin has been reduced to 40 units. This could probably be explained by the fact that with better absorption of insulin, a smaller dose sufficed to control her condition. Credit must also be given to the patient's better understanding of her diet.

In another instance, a woman was depending on her husband to give her insulin injections although there was no reason why she couldn't give them herself. She was assisted in class with self-administration of insulin and now admits that injections are not painful as they were when administered by her husband.

One man attended three classes. In one class he learned how to test his urine for sugar. Previous to this time he had not been testing his urine and had been over-eating. He thought that a "hard-working man" needed 5 or 6 slices of bread at a meal. A tool of learning used in class is a "diabetes diary," which the patient keeps for a week. All food *actually* eaten is recorded. The urine is tested and recorded four times a day, at mealtimes, and again at bedtime. Through his diary the man learned that the five or six slices of bread caused him to have orange urine tests. He cut down to two slices of bread at a meal as prescribed by his doctor and his urine tests were then negative.

Another means of education used by the unit is a monthly newsletter. The newsletter is sent to all diabetics on the register, physicians who are interested in the program, public health nurses, and social agencies interested in the diabetic. This letter is primarily for the diabetic and his welfare. Each month a timely topic is prepared. A summer-month issue gave suggestions for cool drinks and offered classes for canning foods without sugar. In other issues insulin injections and urine testing have been discussed. Recent advancements in science concerning the diabetic were discussed in another issue.

IN A PILOT STUDY to determine the effect of diabetes on public health nursing services, visiting nurse associations reported as shown in the table on page 12.

The range from less than 1 percent to 14.8 percent of morbidity visits is notable and will require more study. Any disease which requires up to 15 percent of morbidity visits and can be expected to increase, is a developing problem. By anticipating these problems, nurses can be prepared to meet them.

Diabetes affects the patient, his family, and his descendants. When a patient is told he has diabetes, he is being told of a condition that he must live with throughout life. The treatment is planned and maintained for life. The patient's life can be long, happy and productive if the patient knows the nature of diabetes and learns how to control and manage his diabetic condition. The doctor, with periodic examinations prescribes the balance of diet and insulin, depending on the patient's activity. The public health nurse has an important role in supplementing the doctor's instruction. It should be emphasized that the doctor gives the patient the guide in his control and management, but it is the patient, himself, who is the deciding factor in carrying out the properly prescribed treatment. In the not acutely ill diabetic patient, the evaluation of the care depends on the degree the patient has been motivated in his good self-management. This good self-management results in a more productive, longer, and happier life.

SERVICE TO DIABETIC PATIENTS BY SEVEN VISITING NURSE ASSOCIATIONS

Organization	Percent visits diabetics	Increase in last 2 years	Carry diabetes indefinitely	Number of instruction visits
VNA of Los Angeles, Calif.	5% (approx.)	No noticeable	Individual consideration	Average 2-6
VN Staff, City of Seattle, Wash., Dept. of Health	Less than 1% of all visits. 2% of morbidity		Do not plan to carry indefinitely	Not limited to instruction visits
VNA, Council Bluffs, Iowa	About 6.5%	Slight increase	Yes	
VNA, Houston, Texas	About 2%	Not definite increase	No	Average 3
VNA, Brooklyn, New York	14.8% of morbidity visits	Increase 3%	No	Average 5-8
Salt Lake Community Nursing Service, Salt Lake City, Utah	Less than 1%	No	Yes	As many as necessary
VNA, Dade County, Miami, Florida	10%	New organization. No available figures	No	Average 6

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NURSING IN A DISTRICT HEALTH DEPARTMENT

HAZEL V. DUDLEY, R.N.

ANY CONSIDERATION of the future of public health nursing services involves recognition of the likelihood of the development of full-time health units. This discussion deals primarily with the effect of district departments of health on other public health nursing services and organizations.

We will always have voluntary public health nursing agencies. Up to this time they have provided a large part of our public health nursing program, and this is especially true of bedside nursing. But many believe the new pattern of public health nursing organization depends upon the development of district health departments—or local health units as they are frequently called.

At present in Connecticut public health nursing is administered by 231 different official and nonofficial agencies employing a total of 555 public health nurses. This does not include those in industry. The 104 voluntary agencies with 323 nurses on their staffs carry the major responsibility. The tax-supported agencies include 98 boards of education with 110 nurses and 29 health departments and other tax-supported agencies with 122 nurses. Of the total number of agencies (which includes 80 boards of education) 158 are one-nurse agencies. Only 10 agencies in the state employ more than 10 public health nurses. Often several different public health nursing groups offer service in one community. Duplication certainly occurs and one must question whether budgeted funds are being used most economically in such situations. At the same time there are many lacks. Forty-one towns have no public health nursing service at all except that for the school age child. While in general there are public health nurses in the ratio 1 to 3,428 population, some communities have only 1 to 6,000.

The citizens of Connecticut spend approximately $1,500,000 each year to provide these public health nurses. Are we getting the most from this investment? Or are we content with a pattern which was satisfactory 40 years ago, with no regard for the advances in public health administration of the last two generations? Are full-time health units the answer?

Every community needs a complete public health program, not just a part-time health officer and one or more public health nurses. Public health nurses themselves realize that more is needed, and that they function best as members of a well qualified health team.

The advantages to public health nursing of being part of or closely coordinated with a full-time health department are many. This type of administration attracts more qualified public health nurses, as they are always looking for appointments on the staffs of public health agencies set up on modern lines. To work in a program headed by a trained public health officer offers greater professional security and satisfaction to a public health nurse than to flounder alone in a set-up reminiscent of a one-room school. Working as a

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member of a professional group, too, has more appeal to most public health nurses than the isolation of a one-nurse service.

Public health nursing agencies want the administrative leadership of a modern qualified health officer who studies the health problems of a community, plans and guides a program to its particular needs. Such a health officer determines if the tuberculosis rate, a high incidence of rheumatic fever, an unusual infant mortality, or an alarming number of diphtheria cases, claims first attention. He does not wait until a complaint has been made, an emergency had arisen. He surveys the community for its hazards to health and plans to eliminate them before they have caused illness or death. He arranges an educational program to help the people learn how to enjoy more abundant health.

Public health nurses on their visits frequently see unsanitary conditions which need the expert help of a sanitarian—wells receiving surface drainage, poorly placed septic tanks, questionable restaurants. Recently a rural school nurse in Connecticut told of her efforts to secure a safe water supply for a rural school which was using an open spring. She had arranged for a visit from a sanitarian from the State Department of Health who investigated and made recommendations. But it was difficult to persuade the people in that town to find another water supply for their school when they had been using that spring for 20 years. A full-time sanitarian in the area would have discovered and seen to it that the hazard was eliminated many years earlier.

Public health nurses in the rural areas need more nursing guidance. Those who have read Haven Emerson's *Local Health Units for the Nation* know that a basic minimum of 1 supervisor to 9 staff nurses is advised. In Connecticut, as of January 1, 1948, there was an average locally of 1 full-time supervisor to 12 public health nurses. However, the majority of these were employed by the large agencies in the urban areas, which had a proportion of 1 supervisor and administrator to 5 staff nurses. It left, however, approximately 300 public health nurses in smaller communities without the guidance of full-time local supervisors. The state consultants gave these nurses as much assistance as they were able but they needed closer and more frequent help with their problems on the local level.

It is also a function of public health nursing supervisors to plan in-service educational programs for the public health nurses of all the staffs within the area. The health officer and the sanitarian may often participate, with the result, a better knowledge of the work of each and more coordinated teamwork.

How helpful it would be to a new public health nurse to have the concentrated assistance of an experienced supervisor in her orientation to the public health field; and to a public health nurse who has worked only in an urban area in learning to deal with the differences found in a rural situation. The other day a public health nurse in a remote part of the state telephoned the State Health Department for guidance on a problem she had met. She said, "If we had a district department of health, I'd take this to my district supervisor." A district department of health would provide needed technical guidance and a continuous in-service education program for rural public health nurses.

There is great need for closer coordination of public health nursing in Connecticut. How often do representatives of the several agencies in one community sit down together to outline plans and policies for the best service coverage possible, to determine how they will avoid duplication of service to the same families, to decide on the mechanics of referral of cases, and so on? Coordination is becoming a too-oft heard word, but how many of us have got beyond the informal friendly relationship between staff nurses who encounter each other on the same street? Helping the various public health nursing agencies within the area to coordinate their services could be one of the most valuable functions of the nursing supervisor in the district department of health.

The need for public health nurses to staff a district department of health raises the question of the future of other local public health nursing agencies as well as the method of integration of the services of local agencies

with that of the district department of health.

The public health nursing picture will differ in each district just as it does in each city which has a full-time health department employing public health nurses. We can make suggestions but the final plan must be decided upon by the citizens of each district.

The character and extent of the public health nursing service of a district department of health will depend upon the public health nursing services already available to the area as well as the number of public health nurses on the department staff. The aim of the district department of health will be to supplement the services of local agencies in order that official and nonofficial agencies may together provide a complete service to the people. The estimated need for 1 public health nurse to 5,000 population for a purely educational preventive service and 1 to 2,000 for a complete service including bedside nursing has been stated repeatedly. In Connecticut, we are all in agreement that we want to continue a public health nursing service which includes bedside nursing. In this we have an advantage over much of the country.

It is unlikely that many district departments of health could immediately budget for 1 public health nurse to 2,000 population. This would increase greatly the cost per capita of a district department of health. However, the combined forces of a district department of health and the private agencies within the area might well secure this proportion. Each district health board and staff would work out suitable and workable cooperative plans with the health agencies in the area.

There is a growing realization on the part of all professional public health workers in both official and voluntary agencies of their dependence on citizens of their area. The public health nurses of a district department of health need lay advisory committees, perhaps in each town or nurse's area. The boards of the voluntary public health nursing agencies, where these exist, might serve in that capacity. There should be also a lay advisory committee for each district department of health, with representation from the local committees.

Connecticut excells in the number of citizens who are informed and concerned about public health nursing. These hundreds of health-minded lay people are a great potential force in implementing the next steps in public health organization.

Professional workers also have tremendous responsibility for fostering a more up-to-date public health program in Connecticut. We aren't satisfied to travel by horse and buggy today. We use automobiles and fly when we can. It is time to leave behind our old-with their educational program.

In planning for the future, we must retain what is good of present practice and at the same time take advantage of known improvements. From a public health nursing point of view, we want to continue the fair ratio of public health nurses to population which we have in Connecticut, adding more nurses as we can. We want to retain the unusually fine lay participation and support in our state. We want our public health nurses to continue to provide bedside nursing service combined with their educational program.

To what stars shall we hitch our wagon? We want all of our Connecticut communities protected by health units under the administrative direction of full-time qualified health officers; we want our public health nursing programs to provide generalized family health service as a part of or coordinated with the work of such departments; we want the guidance of qualified public health nursing supervisors. Progress in public health nursing in Connecticut depends upon the development of district departments of health.

PROBLEMS OF COLOSTOMY PATIENTS

How a committee organized a plan for the improvement of care for the patient with a colostomy which might well be adapted to similar planning for other types of patients.

VIRGINIA C. DERICKS, R.N. and KATHRYN A. ROBESON, R.N.

AT THE NEW YORK HOSPITAL a plan of nursing care for colostomy patients has recently been devised, which affords the patient both psychological reassurance and practical assistance during a very trying period of his life. Through the coordinated efforts of a committee especially designated to study this problem, a planned program was set up which begins in the preoperative period, just as soon as surgery is contemplated, and continues until the patient is satisfactorily adjusted within his own home, among family and friends.

Interest in the study of colostomy patients was first stimulated by graduate nurses working on patient problems which were presented at the in-service program. Comparisons were made between patients who had adjusted well, with little or no change in their daily living habits, and those who never adjusted satisfactorily, or at least required a much longer period of time than others. Why was this so? What factors were involved to cause this difference? Questions were raised in relation to the types of irrigators most suitable for use, odor control, necessity for wearing a bag, recommended diet, and the like. The need for instituting a definite program in which a step by step approach is used to teach the patient practical information about caring for himself was soon made apparent.

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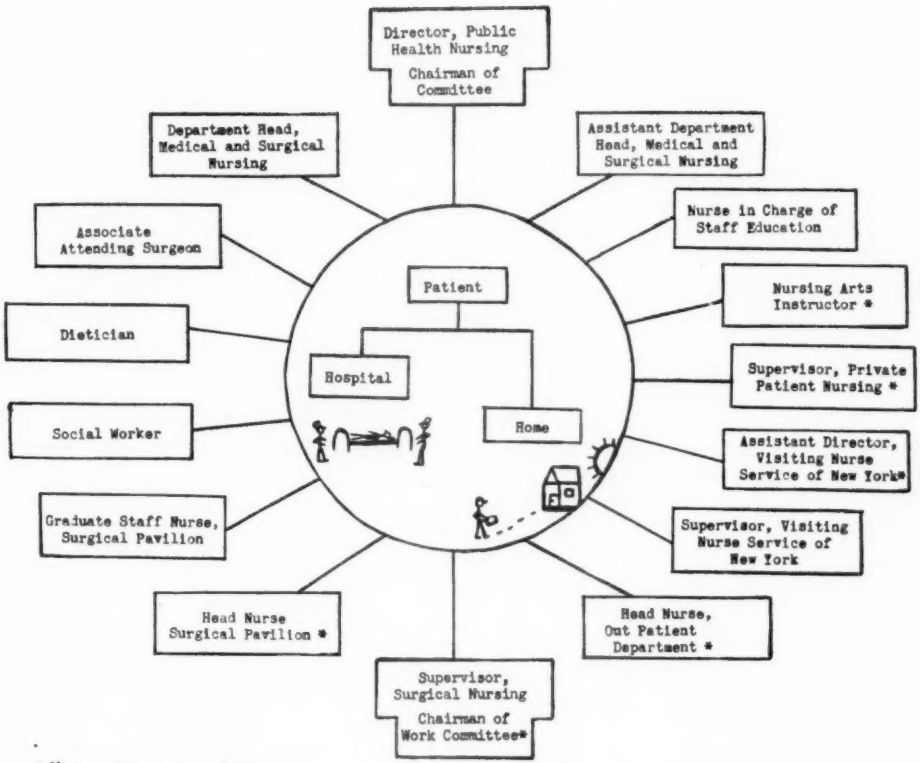
COMMITTEE ACTION

The committee selected to formulate such a plan was composed of representatives from the various services, who, directly or indirectly, influenced the type of care administered to the patient. Committee membership included such persons as the surgeon, department head of medical and surgical nursing, graduate staff nurse, social worker and others. At the initial meeting a subcommittee or "work committee" was formed, composed of nurses working in varied situations, to represent several different points of view in determining the scope of this problem. (Figure 1.)

Investigation was carried out by observing and conducting interviews with at least thirty-five patients on the ward and private pavilions, in the out-patient department, and in the patients' homes. Many valuable suggestions were offered, both by the patients, and by persons caring for the patients. Acting on these suggestions an organized plan of care and booklet of instructions was prepared and put into use on an experimental basis. The following discussion explains the results of the committee's investigation.

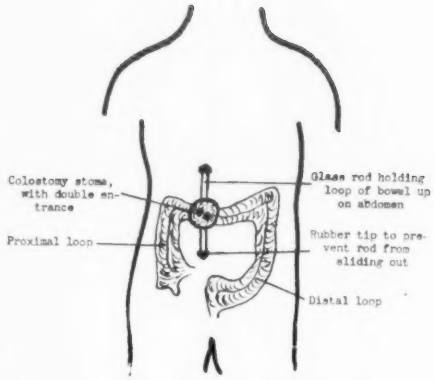
REASSURANCE OF PATIENTS

Almost every patient interviewed expressed the desire to be better informed on the type of operation contemplated, and the reason why



* Member of work committee

Figure 1. Coordinated committee action contributing to the patient's plan of care (The New York Hospital and Visiting Nurse Service of New York)

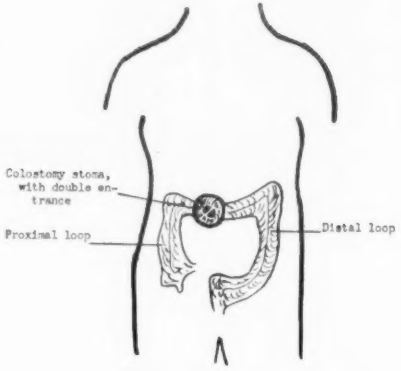


A. Transverse Colostomy With Glass Rod in Place

The glass rod is used to exert an upward pressure on the bowel, thereby interrupting the continuity of the lumen and preventing the fecal stream from passing from one loop to the other.

About the fifth postoperative day the bowel is opened with a cautery, producing a proximal and distal loop. This allows the bowel contents to drain out onto the abdomen; and irrigations are soon begun.

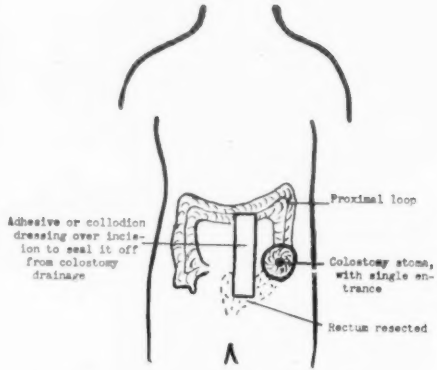
The dressing illustrated in figure 4 may then be used. To insure a snug fit of the waterproof material around the stoma, the glass rod is moved back and forth so that it will pass through the opening without increasing the size of the hole in the material. Gauze props are then placed beneath the glass rod, and the dressing is applied.



B. Transverse Colostomy After Removal of Glass Rod

As soon as the open portions of bowel are able to maintain their position independently, the glass rod is removed by the doctor.

During an irrigation the proximal loop (leading from the stomach) eliminates the bulk of fecal return. The distal loop (leading to the rectum) eliminates mucus and sometimes fecal particles. The transverse colostomy is usually a temporary procedure until further surgery is performed.



C. Colostomy With Abdomino-Perineal Resection

With this type of operation there is only one loop to irrigate. A large incision has been made on the abdomen through which the abdominal contents have been explored, and also on the perineum through which the rectum has been resected. Since the patient is left without a rectum, this is a permanent procedure.

Figure 2. Diagrammatic sketch of colostomies commonly performed at the New York Hospital

it was considered necessary. It was felt that reassurance could be most effective if emphasis was placed on three main phases (1) high incidence of people who have the same type of operation and are able to continue with their everyday activities as before (2) continued *normal* functioning of the body, regardless of the new opening to accommodate bowel discharges (3) looking forward to future regularity and control of bowel movements, *not* continuous and spontaneous drainage. The majority of patients originally did not know what a colostomy was and thought it was a rare condition. One patient described his feeling as "having to live like an animal."

All patients felt that a booklet of instructions would be helpful, especially if they could take it home and refer to it later, as problems arose. During the course of this investigation the committee prepared a small booklet which answered in simple and reassuring terms the questions most commonly asked by persons with a colostomy. It was divided into four sections (1) general information about the colostomy and its care (2) foods included in a low residue diet (3) the irrigation procedure and, (4) a blank page for recording special instructions for the patient's individual case.* It was felt that talking with another person who had a colostomy would also be very helpful.

BOWEL REGULARITY

The three common factors influencing bowel regularity were found to be diet, irrigations, and emotional status.

Diet. For most patients there seemed to be a direct relationship between the taking of a regular diet and the establishment of bowel regularity. Actually there seemed to be no reason why the colostomy patient could not take solid foods just as soon as his general postoperative condition and wound permitted. Best results were achieved on a regular diet, with the elimination of those foods which caused the patient to have diarrhea, gas formation, or constipation. Some patients could not tolerate onions, some baked beans, others stewed fruits. But this was entirely on an individual basis and varied with each patient.

Irrigations. In irrigating the colostomy, the position desired by most patients was to be seated on the toilet. The majority of patients had satisfactory results with a warm tap water irrigation once daily. The most common length of time for irrigating was one hour, although the time ranged from 20 minutes to several hours. In some instances the patients never irrigated, but had regular bowel movements by paying attention to diet alone. Two patients irrigated twice daily. These were elderly persons who had diarrhea. The amount of water required for irrigation varied between 1 pint and 8 quarts, most commonly 1 to 2 quarts. In most instances it was not necessary to irrigate "until clear." A more satisfactory and less exhausting irrigation could be carried out if the amount of water was determined by its effectiveness in producing a satisfactory bowel movement, and by noting when drainage was controlled between irrigations. Patients were usually able to determine the amount of water required after experiencing several irrigations.

The hour of day selected for performing the irrigation was considered very important from the standpoint of affording a designated time when the bathroom was not in constant demand. It was essential that the hour chosen in the hospital coincide with the patient's home pattern of living. One patient, recently discharged from the hospital apparently "well adjusted," was asked to leave his rooming house because he was "monopolizing" the bathroom. The social worker pointed this out as a common problem. Rooming house proprietors often discouraged such people from renting rooms on the basis that it necessitated prolonged or frequent use of the bathroom and an unavoidable amount of "untidiness." Most patients maintained that problems of this nature could be solved by careful selection of a desirable hour for irrigating, or by use of a commode in the bedroom, as

* A limited supply of booklets is available and a copy may be obtained by writing to The New York Hospital, Nursing Office, 525 East 68th Street, New York 21, N. Y. Enclose 24 cents to cover cost and postage.

well as attention to personal hygiene and proper care of equipment. They suggested that this be learned before the patient leaves the hospital.

Three of the irrigators now available on the market (Figure 3.) were used on patients representing various types of colostomies commonly performed at the New York Hospital. (For diagrammatic sketches showing appearance of these colostomies on the patient, see Figure 2.) It was the consensus of the nurses working with these patients that no one type of irrigator was able to serve the purpose adequately for all patients. Each irrigator presented certain advantages over the others and could be used more effectively on specific groups of colostomy patients, depending upon individual differences such as, position of the colostomy on the abdomen, size of the opening and amount of protruding bowel, appeal of irrigator to the patient, position assumed by the patient during the irrigation, and ability of patient to pay for equipment.

Emotional Status. In working with these patients it was evident that no matter which type of irrigator was used, if the patient had confidence in it and was given *adequate reassurance* as to what he might expect from his colostomy in the way of drainage, dressings, irrigations, et cetera, there was often a reduction in the number of bowel movements per day, and a more rapid return to regularity. At least four patients became regulated immediately after irrigations were started; that is, they had no drainage between irrigations at any time while they remained in the hospital. The time that the first irrigation was performed varied considerably, depending upon when the colostomy was opened, the consistency of the stool, and other factors. Oftentimes the doctor performed the initial irrigation to clarify the position of the loops and to determine the freedom of passage. This was usually performed with a small amount of water, 100 to 500 cc.

DRESSINGS

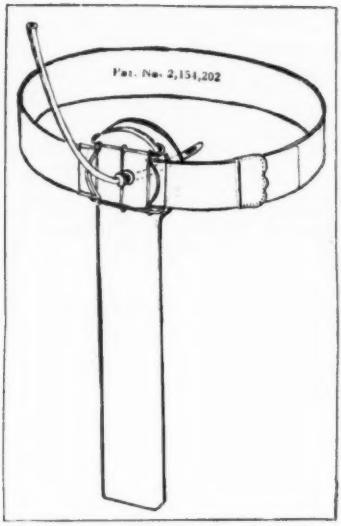
A common source of worry among the patients was finding a suitable type of apparatus or dressing to wear over the opening. How much unnecessary fear and worry might have been spared these patients if they had been given the assurance that eventually all they would need to wear over the colostomy was a small piece of gauze, or cloth dressing, held in place by an elastic belt or girdle! So many patients, and nurses too, thought that these people spent the rest of their lives wearing a rubber bag. Actually there were very few patients returning to clinic who found it necessary to continue wearing a rubber bag. In the beginning, before regularity was established, spontaneous discharge often constituted a serious problem. After experimentation with various types of dressings, the work committee recommended the dressing illustrated in Figure 4 as the most satisfactory type dressing during the period before regularity is established. Upon discharge from the hospital, the patient sometimes wore a bag, but he learned that this was a temporary measure only, until regularity was established. It was interesting to note that before the teaching program was started, all patients were sent home with a colostomy bag, while at present many become regulated while they are still in the hospital, and require no bag on discharge, a saving in both money and "peace of mind."

ODOR CONTROL

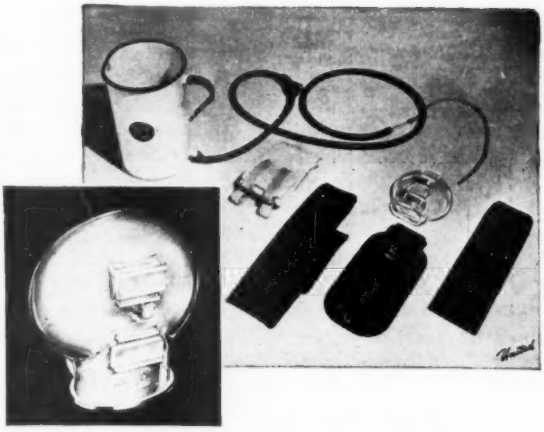
As the bag problem was solved, so the odor problem could be dealt with more easily. There was apparently no truth in the saying: "If a person with a colostomy is in the room, he can be detected by his odor." While it was realized that rubber goods tend to hold odors more readily than some other materials, if the patient was taught proper hygienic care of the skin and how to wash the equipment he used, no odor was noticeable.

SKIN CARE

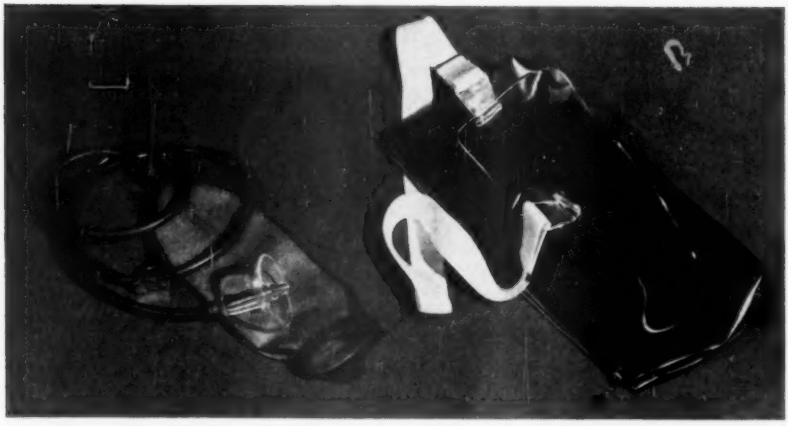
Members on the work committee experimented with the use of various ointments and pastes commonly recommended for protecting the skin around a source of drainage. Such preparations included zinc oxide and castor



A. Gricks Colostomy Irrigator. Shows rubber irrigating cup with flexible frame, belt, and catheter; set may also include rubber extension, and colostomy bag.



B. Binkley Colostomy Irrigator. Shows plastic irrigating cup, rubber extensions, can and tubing, catheter, belt, and colostomy bag.



C. Patten Colostomy Irrigator. Shows plastic irrigating tip, bag and tubing, plastic deflector with belt, and carrying kit. No catheter is required.

Figure 3. Types of colostomy irrigators used while formulating the plan of care

oil ointment and aluminum paste. These preparations adhered very well to the skin, so well in fact, that they could not be satisfactorily removed by the use of soap and water alone, since hydrocarbons are insoluble in water. Mineral oil, however, dissolved them and removed them readily. Several disadvantages were found in using these preparations routinely: (1) they tended to cover up an irritated area so that it was less readily observed; (2) in the process of removing the ointment each day, the friction exerted often caused irritation on a skin which previously had been free from irritation (3) since rubber, mineral oil, and the skin preparations named are all hydrocarbons, and therefore are soluble in each other, an expensive piece of rubber equipment would be destroyed if in contact with these preparations at frequent or prolonged periods of time.

In the experience of this committee, the skin remained in best condition when no ointment or pastes were used. Best results were obtained when the skin was washed with soap and water, dried thoroughly, and powder applied as desired. In some cases it seemed desirable to apply oil in order to prevent the dressing from adhering to the colostomy bud, thus causing bleeding when removed. If drainage occurred several times a day, the dressing shown in Figure 4 was usually sufficient protection for the skin. However, if the skin was already irritated it proved advantageous to experiment with various skin preparations in an attempt to discover which was most suitable for the individual patient.

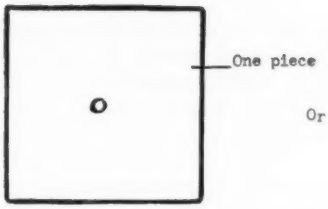
PATIENT TEACHING

The importance of patients learning to care for themselves *gradually* cannot be overemphasized. One patient expressed his gratefulness for knowing how to change his dressings before being discharged, but he also pointed out how surprised he was when the nurse suggested his doing this for the first time. And although she secured all the necessary equipment and supervised the procedure, he felt as if he were being "imposed upon." He stated that he would have accepted the suggestion more readily if a gradual approach had been used, and if he had been acquainted earlier with the fact that eventually he would take care of his colostomy without assistance.

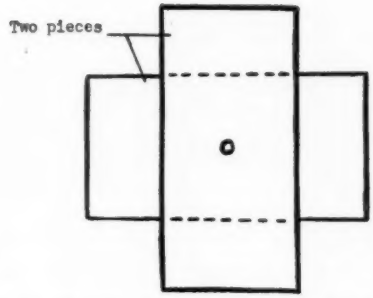
Frequently nurses expressed the desire for more detailed information to be given the nursing staff concerning the explanations given to the patient by the doctor. For example: What was the patient told in relation to his diagnosis? How did he react when he learned of the necessity for performing a colostomy? Did he realize the procedure was to be a permanent one? It was not at all uncommon for nurses to find that efforts to instruct the patient intelligently were handicapped by insufficient information concerning the extent of the patient's knowledge. This led to an agreement between the medical and nursing staff whereby the doctor recorded the information he gave to the patient and family on the progress notes of the patient's chart. Here it was easily accessible to the nursing staff, both day and night, for use in planning the teaching program.

OBTAINING SUPPLIES AFTER DISCHARGE

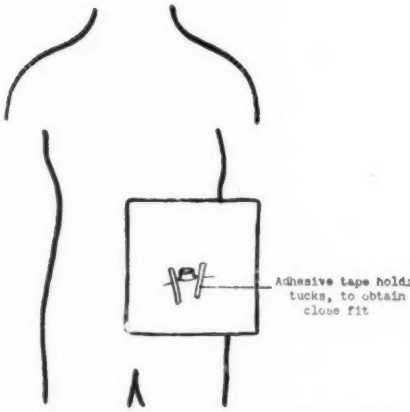
The problem of obtaining supplies after the patient left the hospital was frequently encountered. In one instance the hospital nurse and visiting nurse visited the home of an elderly colostomy patient who was still confined to bed and in need of an "irrigation and dressing." She had been discharged from a hospital without adequate equipment or instructions as to her care. A box of dressings from the local cancer committee was expected in the mail, but as yet had not arrived. Since there was not even an available rag in the household it was necessary to wash the soiled dressing and reapply it as best we could. Numerous patients stated that they had encountered similar problems, many working out the solution by having a relative go from store to store looking for suitable dressings at reasonable cost. Most patients eventually learned to purchase dressings from some of the large department stores, from surgical supply houses, and from local drug stores. Obviously, each patient upon discharge from the hospital should be provided with whatever irrigating equipment is necessary plus a



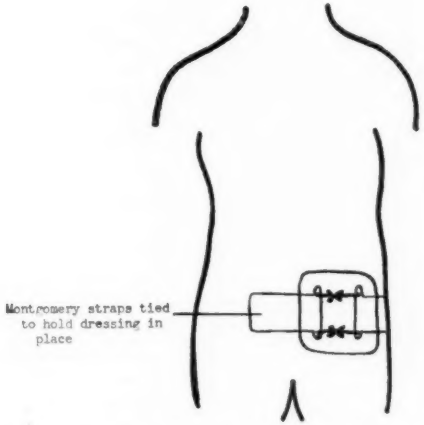
Step I. Select a piece of waterproof material (koroseal, rubber dam, oiled silk, wax paper) approximately 1½ feet square. Cut a small hole in the center the size of the stoma.



If available materials are narrow, use two pieces instead of one.



Step II. Fit the hole over the stoma making certain that a snug fit is obtained around the base. If the hole fits loosely, take one or two tucks in the material and tape with scotch tape or adhesive. Place gauze dressings around and covering stoma.



Step III. Fold edges of material over dressing in envelope fashion, folding lower edge up first. Secure in place by means of adhesive Montgomery straps. A binder may be applied for additional support when patient is ambulatory.

Figure 4. Steps illustrating the construction and application of colostomy dressing

temporary supply of dressings to last until he is able to make the necessary arrangement for replenishing these supplies as needed.

PLAN OF CARE

Our "Plan of Nursing Care for Colostomy Patients" is included on pages 26-27. In order to prepare this plan, members on the work committee met weekly for the first two months, and monthly thereafter. Meetings of the large committee were held whenever further guidance and advice were required. With questions and reports of the work committee carefully organized, only four meetings of the large committee were necessary during the six months it took to prepare the plan.

From the beginning of committee activity the representative from the Visiting Nurse Service of New York participated in setting up the "plan." It was obvious that this plan

could not prove its maximum effectiveness unless the nurses assisting the patient after discharge were informed about it. This necessitated a cooperative policy for the care of colostomy patients referred from the New York Hospital to the Visiting Nurse Service of New York. This policy included provision for a description of services rendered by the hospital, the plan of nursing care, and the booklet of instructions given the patient at the time of hospital discharge. It also included a section on the selection of patients for referral for home nursing care. This selection was based on the following criteria: (1) patients who indicated during hospitalization that they were insecure, indifferent to their condition, or who needed help in the transition from hospital to home care (2) patients who were not physically able to progress to the stage of independence where treatments could be done without assistance (3) patients who would probably never be able to assume responsibility for their own care, but would require care and supervision from a member of the family. Patients who have a poor prognosis, but who may be, at the time of discharge, fairly independent, could be referred for one visit soon after they returned home. They could then be encouraged to call the nurse when the need arose. A home visit was desirable before the patient was discharged from the hospital to help the family prepare for the patient's return home (1) if either the family or the patient did not accept the patient's condition and were apprehensive about his return (2) if the patient were alone and friendless (3) to determine whether conditions were such that he could go back to his previous living arrangement and (4) if satisfactory information about the home situation could not be obtained so that teaching during hospitalization could be directed toward this. The cooperative policy also included a description of the method of referral and of the public health nurse's report of her home visit.

This policy was approved by both organizations and signed by the director of the hospital and the executive director of the Visiting Nurse Service of New York. It was mimeographed and made available to hospital personnel concerned with the referral of patients, as well as to all the local centers of the Visiting Nurse Service of New York.*

The general cooperative policy was important, but equally important was the individual referral of the patient. An interagency referral form was accepted for this purpose.** This form provides for intercommunication between all of those concerned with the patient's care and welfare. It includes identifying data, medical diagnosis and prognosis, physician's orders and instructions signed by the physician, the report by the hospital nurse, dietitian, occupational therapist, the report of the medical social worker, and space for the report of the home visit by the public health nurse. This form is sent in duplicate to the Visiting Nurse Service of New York, and the public health nurse completes the form by recording her home visit. The completed form is returned to the hospital and attached to the patient's record. If the personnel in the clinic have additional orders or information for the public health nurse, the Continuation Sheet is used. The public health nurse may use this sheet to keep the clinic informed of the home situation. The referral form and reports from the Visiting Nurse Service of New York are all routed through the social service department of the hospital. The social service worker forwards reports to the nurses interested in the various departments. Referral of private patients may be initiated by the physician or the nurse in the hospital. Reports of the home visit in this instance may be sent directly to the private physician as well as to the hospital.

THE PATIENT PROFITS

A plan for the continuity of nursing care

* Additional information or copies of the cooperative policy of the New York Hospital and the Visiting Nurse Service of New York, and the agreement may be obtained from the Visiting Nurse Service of N. Y., 262 Madison Ave., N. Y. 16, N. Y.

** The Greater New York Inter-Agency Referral System Guide and samples of the referral form which is generally used between agencies in New York City, may be obtained from the United Hospital Fund of New York, 8 E. 41st Street, New York 17, N. Y.

is only effective if the patient profits from its use.

Mrs. B. was admitted to the New York Hospital for a colostomy operation. She was told of the need for the operation in the clinic before admission. She accepted the explanation of the need for this procedure, but admitted she was not sure she understood all it entailed. On admission, Mrs. B. was given an explanation again of the operative procedure about to be performed, and told by the nurse what she might expect in the way of nursing care and why she would be asked to participate in her own care as soon as she was physically able.

After surgery, Mrs. B. progressed very nicely. She was cooperative and interested in becoming independent in her care. She expressed some of this interest before her surgery in a conference with the medical social worker. She lived with her son and daughter-in-law and their three small children in a third floor walk-up apartment in a crowded section of the city. She had not discussed her condition with either her son or daughter-in-law. She had her own small room, but the small apartment was crowded. She was not sure she would be welcomed back if they knew of the care she would need following surgery. The social worker asked the son to come to the hospital for a conference. It was obvious that he wished to have his mother return home, but was apprehensive about her care. He felt that since his wife had the three children to look after, she was already heavily burdened by the problems of rearing a family in a crowded city area. The problem in this instance was to help Mrs. B. become as independent as possible so that when she returned home her care would not necessitate disruption of the family routine, and make as few demands upon their time as possible. It was necessary to help the son and daughter-in-law to understand Mrs. B.'s condition and find ways of including her care in the family plan and allow her to do the things she was physically able to do even if she helped only in a small way. A public health nurse visited the home while Mrs. B. was still in the hospital. She discussed the patient's care with the daughter-in-law. The daughter-in-law was much relieved at the end of this conference and began to formulate plans for the patient's return. She told the nurse that the best time for Mrs. B. to use the bathroom for a length of time without interruption was about 10:30 a.m.

A report of this visit was sent back to the hospital immediately and the patient's irrigations were planned for this time during the period of her hospitalization. When Mrs. B. was ready for discharge she was fairly independent in caring for her colostomy, but was still apprehensive about doing this at home. She was discharged in the afternoon and was informed that the visiting nurse would visit her in the following morning to assist her with the first irrigation in the home. The information on the referral form sent to the Visiting Nurse Service of New York provided the public health nurse with a clear picture of the patient's condition, her general acceptance of her illness, the problems encountered in her irrigation and hospital care, and a complete picture of the family situation recorded by the social worker. Duplication of teaching on this first visit was unnecessary. The nurse knew exactly where to begin and what to expect of Mrs. B. The daughter-in-law was prepared to observe the nurse so that she might understand and help on succeeding days.

On the second visit Mrs. B. and her daughter-in-law both decided they could manage without the nurse's help. The entire procedure seemed so simple. However, a few weeks later, when Mrs. B. had difficulty in regulating bowel movements because of something she had eaten, the family asked the nurse to return for another visit or two.

Mrs. B. is now completely independent. She assists with the family shopping and baby sitting. She plans for afternoons out with some of her old friends. Her son and daughter-in-law know that if Mrs. B. becomes dependent and needs help again, that the visiting nurse may be asked to visit and assist with her care at home.

This project is one of the first in the New York Hospital wherein the nursing group has taken the leadership in preparing a plan of care for a specific group of patients which required the cooperation and collective activity of other departments. Somewhat similar plans have been worked out for the nursing care of premature infants and postpartum care of primipara, but this is the first such plan instituted for the adult medical or surgical patient. Since it has proved such a successful venture, it is expected that this method will be employed in organizing plans of care for other types of patients as well.

PLAN OF NURSING CARE FOR COLOSTOMY PATIENTS

	CARE	METHOD OF ADMINISTERING CARE
Stage I Pre-operative period. When surgery is contemplated and there is a possibility of performing a colostomy.	Orientation of patient and family to colostomy A. Explanation of term "colostomy" B. Necessity for performing operation C. Emphasis on normalcy of body function, and on high incidence of people who have this type of operation D. Assurance that nurses will assist and instruct patient during post-operative period	Doctor confers with patient, or with responsible member of family as soon as operation is decided upon. Doctor records how much information is given to patient and to family in progress notes on patient's chart, and informs nursing staff. Nurses supplement explanations to patient. If patient or family still finds difficulty in accepting operation, refer patient to social service. Arrange for social service worker to see family during visiting hours. Nurse confers with patient to determine what foods are best tolerated, and which foods cause diarrhea, so the post-operative diet can be planned. Send list of well tolerated foods and poorly tolerated foods to dietician, and inform her when patient is to have colostomy.
Stage II Immediate post-operative period. While patient is on bed-rest and before he is strong enough to go to bathroom.	Assisting patient to accept colostomy and care for self A. *Dressings, Irrigations, and Skin Care* Patient should learn the following activities gradually: 1. Change dressings 2. Care for skin—cleanse area, apply protective paste PRN 3. Insert tube into opening 4. Hold irrigating device during irrigation 5. Learn about amount and temperature of solution, height of can and speed of flow 6. Learn that although bowel movements may occur frequently now, they will eventually be regulated through diet and daily irrigations B. *Diet* Clear fluids → soft → regular as ordered by doctor. Patient is usually put on a regular diet soon after colostomy is opened. 1. Avoid foods which caused gastro-intestinal upset before operation. 2. Avoid foods which cause diarrhea. Low residue diet if needed. 3. Select foods which patient is accustomed to taking at home, and which afford a balanced diet. (Consider presence or absence of teeth). C. *Arranging schedule of hospital care to coincide with home pattern of living.* Investigate: 1. Most satisfactory hour of day to irrigate colostomy at home 2. Living arrangements for patient, including physical plan	Doctor informs nursing staff of approximate date of patient's discharge, so teaching schedule can be planned. Nurse plans daily teaching schedule and encourages patient to help with care as much as possible. Plan should be written and kept on patient's chart or kardex. 1. Demonstrate procedure for changing dressing and irrigating colostomy (take patient into treatment room for irrigations) 2. Have patient return demonstration of activities listed on left Nurse may arrange for patient to have conference with another patient who is well adjusted to colostomy (If this constitutes a problem, arrange through Out-Patient Department.) Nurse instructs patient in diet and arranges to have measures on the left carried out in the hospital as well as when the patient goes home. If there is a special problem in diet, refer patient to dietician. Nurse confers with patient or responsible member of family to determine what problems exist in the home. If additional help is needed to investigate home conditions, she then refers patient to the VNSNY, using the public health referral form. Information to be included on this form: 1. Investigation desired 2. Diagnosis and prognosis of patient

	CARE	METHOD OF ADMINISTERING CARE
	of bathroom 3. Attitude of family toward acceptance of patient 4. Possibility of obtaining necessary supplies after patient goes home 5. Conditions of work and recreation to which patient will return 6. Responsible member of family who will help patient with care in the event patient is not able to give self total care	3. Status of colostomy—permanent or temporary, number of loops, etc. 4. Type of dressing and treatment patient will require 5. Information which has been given to patient and to family. 6. Description of patient's reaction and of family's reaction 7. Approximate date of discharge Visiting nurse will call pavilion and follow through with written report to inform hospital nurses about home conditions. Nurse arranges schedule of hospital care to coincide with information she has obtained about patient's home conditions.
Stage III Convalescent period When patient is ambulatory and able to go to bathroom by self.	Assisting patient to assume as much care for self as condition warrants, in preparation for going home. A. Irrigation of colostomy in bathroom and care of equipment B. Regulation of colostomy through diet and daily irrigations C. Wearing suitable type of dressing or apparatus D. Obtaining equipment and supplies from hospital for immediate home use E. Learning where to obtain additional supplies after patient goes home—(department store, drug store, etc.) F. Handling special problems 1. Diarrhea 2. Leakage 3. Odor 4. Return to occupation, recreation, etc. G. Arranging for additional help when the patient goes home 1. Clinic appointment 2. Services of the VNSNY. Help with first irrigation if needed. Follow up visits whenever necessary	Nurse obtains equipment for home care (from general stores) and shows patient how to use it in bathroom. She also explains where patient may obtain additional supplies after he goes home. Nurse gives booklet of instructions to patient to which he may refer when he goes home. Help patient follow these instructions in hospital. Nurse and patient observe functioning of colostomy for regularity, leakage, odor, etc. and take measures to solve any problems which rise. If patient is not able to give himself total care, nurse arranges for responsible member of family to come in and observe. Refer patient to VNSNY for home care if indicated. Nurse explains functions of clinic and VNSNY.
Stage IV Home care	Home care and return to community. A. Adjusting to home environment. B. Return to suitable occupation and recreation. C. Handling problems which have persisted in spite of help. D. Follow up of patient's general condition 1. Clinic 2. Visits from visiting nurse as needed	If patient has been referred for home care, visiting nurse visits home day after discharge and helps with first irrigation. She observes patient in home situation, and arranges for future visits as indicated.

MODERN PUBLIC HEALTH MEASURES AGAINST LEPROSY

G. W. McCOY, M.D.

EVEN IN BIBLICAL TIMES leprosy was a problem for those interested in public health, and in Holy Writ we find rules for diagnosis and for prevention, though there has been much difference of opinion as to whether the leprosy of the Bible is the same disease we know today. The word leper is used in the Bible, but it is a term that is anathema to victims of the disease and is disappearing from medical literature. Today Hansen's disease is the preferred designation

There are several clinical types of leprosy, as follows:

1. The lepromatous or skin type which is often progressive and leads ultimately to death. This type is regarded as most likely to lead to new infections.

2. The neural or anesthetic or nerve type, including the subtype, called tuberculoid, which is a relatively mild condition, rarely leading to a fatal issue and usually considered as unlikely to be transmitted.

3. A form clinically presenting elements of the two above, spoken of as the mixed form, which from the public health point of view is to be classified with the lepromatous type, i.e., likely to be transmitted and often resulting in death.

All the clinical forms may present different degrees of severity, from those so mild as to be very difficult to diagnose to those that progress to death in a matter of a few years. All forms often show tendencies to self cure or arrest. The outlook for the patient is now regarded as one of much greater hopefulness than it was even a few years ago.

For practical public health purposes, the diagnosis hinges on finding the characteristic acid-fast organisms (Hansen's bacilli) in preparations from lesions usually of the skin or nasal passages.

The organism must be characteristic in every way to be significant, and it is to be mentioned that preparations from the nasal cavities are likely to be misleading as they sometimes show acid-fast organisms bearing a resemblance to those of leprosy. An organism that occasionally may need to be differentiated is the tubercle bacillus, and here the diagnosis can be made by animal inoculation, the leprosy organism being harmless for laboratory animals. Syphilis probably causes difficulty in diagnosis oftener than any other condition; indeed, in my experience more cases of leprosy are erroneously diagnosed as syphilis than any other condition. This comes about to a considerable extent because the serum of leprosy patients sometimes gives a false positive reaction in the Wassermann and other serologic tests for syphilis. There is no dependable serum nor skin test for the diagnosis of leprosy.

The treatment of leprosy is decidedly more hopeful now than ever before. In addition to general hygienic, nutritional, and symptomatic

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measures we have, thanks to the studies of the medical officers at the National Leprosarium at Carville, Louisiana, medicinal agents more promising than any used in the past. Members of the sulfone group of drugs, especially promin, first used about five years ago, are generally regarded as very beneficial. Perhaps it is too early to say, curative. Promin is very slow in influencing the progress of the infection. Six months or more elapse before there is noticeable improvement and usually a period of years is necessary to lead to arrest of the disease. Promin must be given intravenously but two other members of the sulfone group, diasone and promizole, may be given by mouth These latter drugs have not been in use long enough for a fair appraisal of their value. The sulfone drugs are not without their disadvantages. They may give rise to anemia, kidney damage, and skin rashes. Chaulmoogra oil and its derivatives, until a few years ago, were much used, but final appraisal has seemed to indicate that they have no material value and now have been pretty generally discarded.

THE PURELY PREVENTIVE medical aspects of leprosy must be considered for each patient and each family situation separately. We are still in ignorance of exactly how leprosy is transmitted, but there is a widely held opinion that infancy and early childhood are the periods of life when exposure to an infective case of leprosy is most dangerous. The acceptance of this view does not rule out the recognition of the possibility of the occasional infection later in life. Indeed, I have seen a number of cases in which the disease has been acquired by adults. Until comparatively recently, in the United States, all cases when diagnosed were generally required to be isolated, regardless of circumstances in individual cases. This attitude was to some extent the result of fear and hysteria on the part of the public due to the erroneous belief that leprosy is a highly communicable disease. As the true situation has become recognized, a more intelligent attitude has been adopted by health authorities.

It is now recognized that the danger of infection depends upon several circumstances. As to geographic location, only in Florida, Texas, and Louisiana is leprosy transmitted often enough to make it a public health problem of importance. In California and in Minnesota, transmission occurs rarely, but is not negligible. A recent study in California shows that among about 500 cases reported in this century, less than 25 acquired the disease in the state, the remainder being imported either in the incubation period or in an active stage and chiefly from Mexico, China and the Pacific Islands, including Japan. In Minnesota, over 100 imported cases, chiefly from the Scandinavian countries, resulted in the infection of 7 persons among the American born, mostly in families with an imported case. In other words, the disease shows a tendency to spontaneous disappearance. In a few other areas of the United States, the tendency to spread is so feeble as to result only in an occasional case at long intervals. Charleston, South Carolina, and Savannah, Georgia, fall into this group. In some other areas, there is even less tendency to spread; thus in New England, there has been but a single example of transmission. In New York there is no well established case of infection though there is a steady importation of cases chiefly from the Caribbean area and from South America. Elsewhere in the United States there is no substantial evidence of spread but our information is incomplete.

The second circumstance to be considered is the clinical type of the case. Only cases with lesions in which acid-fast organisms, regarded as the cause of the disease, are found to be regarded as a possible source of infection. Many cases with severe ulcerations and mutilations are of the nerve type and do not need to be considered as dangerous from the public health point of view. The neural subtype, the tuberculoid, is very generally regarded by authorities as being unlikely to be transmitted.

The final important consideration in estimating measures to be taken in respect to any individual case is the age of individuals likely to be exposed to contact. Here the essential

point is that infants and generally children under 10 years are much more likely to be infected than older persons. Indeed, one distinguished authority believes that if exposure of small children could be prevented, the disease would disappear. If one wished to reduce these factors to simple terms, he might say that exposure of children to communicable cases in areas of spread constitute the important hazard. If he wished to put the matter in another way, he would isolate in a special hospital communicable cases in areas where transmission is likely.

Home care and home isolation would serve for many other cases. Non-communicable cases in areas where spread does not occur or occurs only very rarely would not need any special measures. Of course, some cases would need to be cared for in special institutions as a matter of public charity, or on account of the handicaps imposed on the patient by the attitude of the public.

PUBLIC HEALTH NURSE AND LEPROSY

ROSE A. GODBOUT, R.N.

THE ENDEMIC DISTRIBUTION of leprosy or Hansen's Disease occurs in the semi-tropical areas of this country. To public health nurses working in areas of Florida, Texas, California, and Louisiana the disease presents a challenge. The social implications of the disease necessitate that cases be handled on an individual basis and by a nurse who is appreciative of the value of case work. Too, early case finding will be aided by the nurse who is aware of the prevalence of leprosy. Contact examination may be mainly dependent upon the follow-up endeavors of the public health nurse. Public education should also be an inseparable part of the program. The greatest challenge is in the realization that from such nursing activities might come some knowledge that would throw light on the unknown facts of leprosy.

The control of leprosy should be a part of a generalized nursing service. The first step toward the integration of such a program is a survey of the problem in the community served. Such a survey does not mean a mass examination. Instead, information relating to known cases can be gradually compiled in the form of a register similar to one for tuberculosis. Such data can be secured by a review of nursing records, and from health department and physicians' reports, and from hospital admissions. In addition to pertinent information regarding each patient, the register should list contacts and allow space for contact examination. Space for reports of examinations of contacts for a number of years should be available.

The second step in the integration of leprosy control with the generalized nursing program is in-service training. Obviously the services of a specialist, if any is available, should be utilized. Review by the nursing staff of timely articles relating to the disease and case discussions are helpful. A trip by a nurse to the Marine Hospital at Carville for the purpose of observing the management of leprosy proved worth while for one department. Special attention should be given to interviewing technics and case work principles. *The Star*, monthly magazine of the patients of the Marine Hospital at Carville, presents authentic medical information and reveals the attitudes of patients.

The third step is nursing service for patients, suspects, and contacts. From in-serv-

Miss Godbout was, at the time the article was written, director of nurses, Hidalgo County Health Unit, Edinburg, Texas. She is now studying at the School of Public Health, University of Minnesota.

ice training should have come an appreciation of the feelings of the patient; indeed, the attitudes of the patient and his family will require as much consideration as the disease itself. The disease is still surrounded with dread and fears. The patient fears a life of isolation in Carville and the ostracism of himself and his family by the community. The family must be convinced of the sincerity and genuine desire of the nurse to aid them. For the benefit of the family, an informed awareness, particularly in dealing with contacts, should be developed by the nurse. She recognizes that leprosy is a disease of youth, usually acquired in infancy. She knows that a large percentage of the victims present false positive serologic tests for syphilis and that nasal symptoms are often manifestations of leprosy. She learns how to tell the patient honestly and tactfully what the problems of medical supervision are and how he can protect those with whom he lives from contagion.

If ultimate hospitalization is indicated, the patient and his family are guided to accept it. If the patient is to live at home he must receive constant specialized medical attention. The public health nurses' significant contribution in this case will be the same that she makes in other communicable disease services. In leprosy as well as in any other epidemiologically significant disease, early case finding and prevention of the spread are of first importance. But in the case of leprosy prevention and control require that contacts be examined periodically for at least 20 years.

The fourth step in the integration of a program of leprosy might well be a mutual exchange of information gathered from experience. During group discussion the interpretation given such experience may show the need of the staff for more facts. Or it may reveal certain emotional blocks of nurses in dealing with the disease for which help can be given.

Taking the four steps as indicated is not expected to lead to a staff completely prepared to function in leprosy control in an area where definite public health measures must be taken. Instead, the pace and order of the steps should be in keeping with the needs of the individual staff. Meanwhile public health nurses everywhere need not look far to see that they can work continuously to reduce the social complexities of the problem. Public ignorance and misunderstanding have resulted in unnecessary cruelty to those burdened with Hansen's disease. Education aimed at better community understanding can do much to lessen its power to crumple the dignity of the human individual.

EDITOR'S NOTE.—The November 1948 issue of *What's New*, monthly publication of Abbott Laboratories, North Chicago, Illinois, contains an illustrated article on the National Leprosarium: United States Marine Hospital, Carville, Louisiana. Many original drawings in color give the reader a vivid picture of daily life in the sanatorium. Abbott Laboratories informs us that a limited number of copies of the issue are available upon request.

NATIONAL ODD SHOE EXCHANGE

A non-profit "mismated" shoe service, The National Odd Shoe Exchange, is available to men, women, and children suffering from polio, injury, amputation, or other conditions which necessitate mismated shoes.

The Exchange acts as a clearing house to bring together those persons with mutual problems who may have serviceable shoes to spare. The Exchange does not deal in shoes but with names of persons of similar ages and tastes in shoe styles who have available, or are seeking, "mismates."

Founded by its director, Ruth C. Rubin, as an answer to her own foot problem, the service was originally a free service but it has now grown beyond original expectations.

In order that the service be continued an annual registration fee of $3 is now required. This covers the indexing and cross indexing of data necessary to bring together persons seeking mismated shoes.

For further information write Miss Ruth C. Rubin, National Odd Shoe Exchange, 6267 Clemens Avenue, St. Louis 5, Mo.

NURSE AND NUTRITIONIST WORK TOGETHER

And come out with some practical plans for helping families meet the ever-present problem of eating well on little money

CATHERINE LEAMY

MISS MASON, the public health nurse, had long been concerned with the nutrition problems of the mothers she saw on her daily rounds in the rural areas at the south end of the county.

The families lived in every kind of home on every kind of income. Many of them were really having a tough time making ends meet. Many of them were not meeting the nutritional needs of their families, she felt sure. Miss Mason made up her mind to see what she could do about it—and knew she had a strong ally in Miss Seton, the nutritionist. Today she had stopped in to see her the first thing in the morning.

PART I

"Good morning, Miss Seton," said Miss Mason, as she entered the nutrition office. "I really have a problem today!"

"Let's hear it."

"Do you remember Mrs. Stevens? She's the woman I told you about who had such a fine baby last month. She had a pretty hard time when her first baby was born, probably because she wasn't under the care of a doctor. This time she came to the prenatal clinic right at the start. Her food habits were poor but she was eager for help. She took all our suggestions and followed them carefully, particularly when it came to diet. She did everything the doctor recommended too—well, the upshot of it is that her delivery was normal, her baby fine, and she is able to nurse him. She was sold on the idea of the diet, so much so that she's going around telling other people about it. Last week she told a neighbor, Mrs. Lacey, about my help."

Miss Seton laughed. "That doesn't sound like a problem to me."

"It isn't Mrs. Stevens who is providing the problem. Remember, sometime ago you helped me with points on teaching nutrition facts. Well, they worked like a charm with Mrs. Stevens. She had a garden, she canned a large amount of food, and she had a fairly good income. But things are different with Mrs. Lacey, even though she lives in the same country district. She doesn't have as much money or the resources that Mrs. Stevens had. How am I going to help Mrs. Lacey get the right kind of food to produce a strong, healthy baby?"

Miss Seton looked thoughtful. "That's a very real problem. What mothers need doesn't change with the cost of living. Tell me more about Mrs. Lacey and her family. Maybe we can work out a plan together so she can meet her needs. If Mrs. Stevens has talked with her, I think she's probably anxious for help."

"Mrs. Lacey is four months pregnant. She has two children, John, age 8, who is in school where he receives free milk and lunch, and Bess, age five, who is at home. After Mr. Lacey deserted the family two months ago, Miss Prichard, the child-welfare worker, arranged for aid to dependent children—$65 a month. I know that's not very much! But

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the State Welfare Department realizes that. They're working hard to raise these grants. The Laceys pay $15 a month for a house that's just a shack, $15 goes for clothes, fuel and other things, leaving about $35 a month for food. Mrs. Lacey always feels tired, too tired to attempt a garden, and Mr. Lacey wasn't interested in gardening. So, every bit of food except John's lunches must be bought."

"With so little money, it's not going to be possible to buy a completely adequate diet, even using the FAMILY FOOD PLAN AT LOW COST[1] as a basis. But we'll do the best we can. I'm sure we can work out something helpful for Mrs. Lacey. Does she like to cook? Has she any equipment?"

"There's a two burner oil stove with no oven, for summer, and a pot-bellied stove for winter. I didn't ask her about pots and pans, but I saw two or three hanging beside the stove, plus the ever-present frying pan. A well provides the water and summer refrigeration."

"She isn't able to keep much, or use left overs or bake them, is she?"

"No. Miss Prichard and I are trying to get Mrs. Lacey more cooking equipment."

"What kind of meals does Mrs. Lacey get?"

"Monotonous, to say the least. She doesn't know much about cooking. I think she could learn to follow easy recipes if she had them."

"That sounds like she needed simple practical suggestions."

"She really does! The two things that worry me most are milk and protein foods. I can't figure out how Mrs. Lacey can get enough of those for herself and her family with the money she does have for food."

"What foods does she buy now?"

"The children and Mrs. Lacey eat the same thing, except what John gets in school. Cereal and coffee for breakfast. Dried beans, bread and tea, for lunch. Fried potatoes, pickles, sweet rolls and coffee for supper."

"No milk?"

"After she talked to Mrs. Stevens, Mrs. Lacey started buying a quart of milk every day and keeping it in the well."

"Where does she get it?"

"From a neighbor who has a cow, but she has to pay store prices."

"What about meat?"

"She's been buying meat one week and eggs the next."

"Does she get them at the country store in that neighborhood?"

"Yes, and it's like most country stores. It has little variety, high prices, and no delivery service. Food buying is hard for everyone in that district."

"She certainly has food problems!" Miss Seton exclaimed. "Could you give her any help about diet on the first visit?"

"There wasn't much time for detailed instructions. I did suggest evaporated milk, however. I told her about the dangers of raw milk, that the food values of evaporated and whole milk were similar, that if you use a whole can at a time, it won't spoil and that it is cheaper."

"Had Mrs. Lacey ever used it?"

"Yes, but she said she thought the raw milk was better for her."

"Well, she knows better now."

"What about dried milk? Is there anywhere Mrs. Lacey can buy that?"

"Possibly. There is a bakery down near the prenatal clinic that sells it. I have such a time persuading my mothers to use dried milk though, I've become slightly discouraged. They all say it lumps."

"Do you know the pamphlet HOW TO USE DRY SKIM MILK FOR EXTRA NOURISHMENT[2] from the New York City Food and Nutrition Committee? It gives the recipes for using it."

"One easy way I think, is to add it to other dry foods such as dry cereal and salt before mixing them with liquid."

"How does that work?"

"When making hot cereal you add the dried milk to the cereal before pouring it into the boiling water. You can get a lot in—as much as ½ cup to 1½ cup of oatmeal."

"How do you fix it as a liquid?"

"You fill a jar half full of water and then sprinkle the dried milk on top. Shake it well until it is completely mixed—¾ cup of dried milk to 1 quart of water."

"That sounds easy! But I'll try it myself

first, so that I can be really convincing. How much should Mrs. Lacey buy?"

"Let's check her family milk requirement with the U. S. Agriculture Department's bulletin, 'Family Food Plan at Low Cost.' "[1]

"Bess needs 5½ quarts of milk a week, John 5½ and Mrs. Lacey herself 7½. That is 18¼ quarts a week."

"How much milk does John get at school?"

"1¼ quarts a week, that leaves about 17 quarts for Mrs. Lacey to buy."

"She wouldn't buy all dried milk, would she?"

"No. She could buy 1 can of evaporated milk a day, plus 1 extra can, a total of 8 cans a week. Since a can is not quite the equal of a quart of milk, 8 cans would supply 7 quarts."

"How many quarts are there in a pound of dried milk?"

"One pound of dried skimmed milk is equal to 5 quarts of liquid skimmed milk. Two 1-pound packages a week would complete Mrs. Lacey's needs."

"What about the fat that she misses when she uses dried skimmed milk?"

"She ought to use a bit of extra fat fortified with vitamin A to make up for the fat she would have had in whole milk," Miss Seton agreed. "When she goes to the clinic every other week she could buy 4 pound packages of dried milk at each visit. She can also buy some cheese, which is a milk substitute."

"What about cheese, Miss Seton? Could that be used as a meat substitute, too?"

"Yes. ½ pound of cheddar cheese or 10 ounces of cottage cheese give about the same amount of protein as a pound of meat with a medium amount of fat and bone."

"The cost isn't the same though, is it?"

"No, cottage cheese is a good bit cheaper than cheddar, and it's fairly inexpensive to use instead of meat. Cheddar cheese provides considerable calcium, too."

"Cheese can help out with protein but there are other ways, aren't there?"

"Yes, the dried beans you mentioned are good sources of incomplete protein, as is peanut butter. True, their proteins aren't as complete as animal proteins, but they're inexpensive."

"Are eggs complete proteins?"

"Yes, and a good meat substitute from the point of view of food value; if the cost of 8 eggs is less than a pound of lean beef, they are also a good buy. Grade B and cold storage eggs are cheaper and have equal food value."

"Those are all good points, but I bet Mrs. Lacey will ask about cheap buys of meat, too. Are there any these days?" asked Miss Mason.

"Since prices do vary, Mrs. Lacey will have to check with her butcher. Probably that country store hasn't the variety which larger markets might carry."

"Yes and she can't keep a large piece because she has so little refrigeration."

"Another problem, too, is that she lacks an oven. There would be little chance of her preparing many of the good meat extender dishes found in the bulletin, MONEY SAVING MAIN DISHES.[3]

"What do you think she might buy?"

"As a rule, the less expensive buys are tongue, heart, kidneys and brains, and cuts such as flanks, short ribs, chuck, neck plate are also cheaper. These cuts provide meat of good flavor although they are less tender and take longer to cook."

"The amount of bone in a cut has to be considered in relation to the cost, doesn't it? Is fowl cheap?"

"It often seems cheaper in terms of actual cost, but it is easy to forget that there is a large portion of waste to consider."

"The country store often doesn't have tongue, heart, and brains, but it would have cuts like flank, I think."

"Does it have fish? That's a good meat substitute, too."

"Yes, there isn't much fresh fish but canned fish is almost always available."

"Mrs. Lacey could buy the cheaper types then, for example, canned mackerel, pink salmon."

"This all adds up to quite a list of protein foods for Mrs. Lacey! Exactly what are her family needs for the week, Miss Seton?"

"Let's consult the chart again—meat, poultry and fish for the three Laceys adds up to 4¾ pounds a week. Their needs for dried

beans, peas and nuts, 10 ounces a week, and for eggs—17."

"What would she actually buy?"

"Mrs. Lacey could buy a pound of dried beans or peas, or peanut butter two times every three weeks, 1 can of fish or 1 pound of cheese a week, and 2 pounds of meat twice a week. These would give her either meat or a meat alternate nearly every day."

"That doesn't sound too bad. The original meals I outlined won't have to be changed much either will they?"

"No, dried milk with the cereal, cottage cheese sandwiches, and peanut butter sandwiches for lunch and supper, an egg daily, if possible, and either an evaporated or dried milk drink at each meal, will build up the milk and protein for that day."

"We haven't talked about the missing vitamins, have we? Can I make an appointment with you for next month to discuss how Mrs. Lacey is to get the rest of the basic seven foods?"[4]

"Surely, Miss Mason, I'll save time for a conference on your next visit to the office."

Part II of "Nurse and Nutritionist Work Together" will appear in February.

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[1] A family food plan at low cost. Prelim. Misc. Pub. 662, U. S. Department of Agriculture, Bureau of Human Nutrition and Home Economics, Washington, D.C., 1948.

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NFIP Contributes to Nursing

(Continued from page 2)

Foundation for Infantile Paralysis—"The March of Dimes". The field service given by consultants 1939-1948 has included 46 states, the District of Columbia, and Canada. The staff has grown to meet the demands of service, from one nurse consultant and one secretary in 1939 to five nurse consultants and four office staff in 1948.

The National Foundation has also through its support of university courses in orthopedic nursing contributed to the advancement of nursing in this field. Short courses in the nursing care of poliomyelitis were established in teaching centers. For nurses whose basic preparation did not include care of poliomyelitis patients these courses have been supplementary. To other nurses they have given an opportunity to learn of new developments.

The National Foundation's contribution to nursing service is well known. The American Red Cross has reported that 1478 nurses were recruited for poliomyelitis nursing in epidemic areas in 1948. NFIP paid not only salaries but also the transportation and maintenance for all these recruited nurses.

In providing advisory service on problems in orthopedic nursing, nurse education in this special field, and nursing service in epidemics, the National Foundation for Infantile Paralysis has been a tremendous factor in improving the nursing care not only of patients with poliomyelitis, but of all patients as well.

LOOKING TOWARD THE FUTURE

JESSIE L. STEVENSON, R.N., P.T.

We are of different opinions at different hours but we always may be said to be at heart on the side of truth.—Emerson

THE PRECEDING ARTICLES in this series* have presented a picture of physical therapy services in local nonofficial and state official agencies. Although the programs differ in certain respects according to locality and type of agency administering the service, there are similarities in all which illustrate fundamental principles of good service, administration, and education.

Availability of service. The concept that a field service in physical therapy under medical prescription and direction should be available in the community without restrictions as to race, creed, economic status, diagnosis, age, or residence requirements is now more generally accepted although still not universally practiced. For example, in some localities physical therapy in the home is provided by an agency which serves only children; or by more than one agency, each of which offers treatment for specific diagnostic groups such as patients with infantile paralysis or cerebral palsy.

The Colorado program illustrates a way in which the official and nonofficial agency can plan together so that a field service may be provided for both children and adults under the administration of the recognized health agency in the state. This arrangement not only makes possible more economical use of funds, time, and personnel, but it provides a more complete service for the patient. Physical therapy is but one component of medical care and it can be most effective when it is an inherent part of the program of an agency providing a health service designed to meet all the needs of the patient.

It is easy to understand why the majority of state agencies for crippled children have limited their services, including physical therapy, to patients under 21 since federal and state legislation has placed limitations on the use of funds.

The advantages of separating children from adults for care in the hospital or convalescent home are obvious. However, when this pattern of separation of age groups is applied in the home an artificial situation is created. It is neither economical nor in keeping with good administrative practice to have one agency provide care for the child in his home and another offer an identical service to the adult.

Other states may be interested in study of the ways in which New York and Colorado have planned service to all age groups within legal limitations.

Miss Stevenson is associate professor of nursing, Vanderbilt University School of Nursing, Nashville, Tennessee.

* In PUBLIC HEALTH NURSING:

Macdonald, Mary. Physical therapy in a VNA (Boston). August 1948, p. 412-418.

Hayward, Louise. Orientation of physical therapists in a public health agency (New York). October 1948, p. 508-510.

Pirimmer, Nora and Gillette, Esther. A state field physical therapy program (Colorado). November 1948, p. 553-556, 558.

Where service is given. The advantages of a physical therapy service in the home have been brought out in all of the articles. Sometimes in an emergency such as the poliomyelitis epidemic in Colorado in 1946, a field service is inaugurated partly because facilities for hospital care are inadequate. However, generally speaking, it is not sound for the public health agency to offer a field physical therapy service in the community unless it is also available in hospitals and convalescent homes where patients receive initial care. Although physical therapy is more effective in a shorter time if started early, gains made in early stages of treatment may be lost without continued care and instruction in the outpatient department and the home.

Treatment centers for ambulatory patients are used to a considerable extent by public health agencies whose program includes physical therapy. Although these will be less needed when physical therapy is more generally available in outpatient departments of hospitals, their advantage in conserving time of the physical therapist thus making treatment available to more patients, in addition to other values pointed out by Miss Gillette and Miss Pfrimmer, will make them useful for some time to come.

Home visits for selected patients are of value even for patients who receive treatment in a center. In Colorado the therapist makes at least one visit in the home of every patient preferably early in the course of treatment. Careful instruction of patient and family has been stressed in all of the articles. Although good teaching may be done in the treatment center as well as the home, an understanding of the home situation is essential to adapt instruction to the patient's needs. If the therapist cannot visit the home herself, she may secure helpful information from the public health nurse or social worker.

In view of the development of rehabilitation centers in many urban areas where physical and occupational therapy are a part of the total service provided, some public health agencies have asked whether a field service in physical therapy should not be administered through the rehabilitation center rather than the public health agency. Because the effect of physical therapy may be counteracted unless the principles upon which it is based are given support by good nursing, this writer believes that coordination of these two services is facilitated if they are both administered by a health agency which serves the family. When administered by separate organizations, inter-agency planning is essential to make full use of all professional services. One way of working together is to interchange consultant services. Much has been said about the contribution of physical therapy to nursing but it should not be forgotten that consultation is a two-way process and that nursing gives as well as receives.

Medical direction. Plans for adequate and continued medical direction are fundamental to a good field service in physical therapy. The methods used by Boston, Colorado, and New York will be suggestive to other organizations which have similar programs or plan to inaugurate them. Administration of a field service by a public health agency facilitates arranging for medical guidance.

Preparation of staff in physical therapy. The American Physical Therapy Association, organized in 1921 with the name American Physiotherapy Association, was the pioneer group which developed standards of physical therapy education. It was not until 1936 that accreditation of physical therapy schools was officially taken over by the Council on Medical Education and Hospitals of the American Medical Association at the request of the APA. At the present time there are two patterns of approved preparation in physical therapy:

1. A program of study ranging from 12-16 months with one of three prerequisites,—graduate registered nurse with two years of college including preparation in physical, biological and social sciences; graduate of school of physical education with similar physical and social science requirements; university science major with three years of college.

2. A 4-year degree program for graduates

of accredited high schools leading to a bachelor of science in physical therapy.

It will be noted that all of the agencies whose physical therapy programs were described, employ at least some members of their staffs who are physical therapists without nursing background. Since many people have the impression that this is entirely a new development, it is of interest to know that the Vermont State Department of Health which offered the first field service in physical therapy in 1915 employed Janet B. Merrill, now technical director of physical therapy, Simmons College, Boston, and a physical therapist whose prerequisite preparation was physical education. Although a limited number of other state health departments and local visiting nurse associations have employed physical therapists with physical education or science major prerequisite preparation, generally speaking, these agencies in the past have preferred physical therapists with nursing background. Recently the situation has changed and there is now a definite trend toward more extensive employment of qualified physical therapists without regard to their prerequisite preparation. In view of increased standards of education in physical therapy which have lengthened the period of preparation, agencies now recognize that it is no longer practical or necessary to expect *all* physical therapists who work in public health agencies to be qualified in two professions—public health nursing and physical therapy.

Those who prefer to employ a supervisor and part of the field physical therapy staff who are also public health nurses point out the following advantages: The supervisor because of her background in general public health nursing can work more easily with the nursing supervisors in correlation of the two services and can relate her staff education and advisory service more readily to nursing situations. Furthermore, the agency can use the staff physical therapists with public health nursing background in a more flexible way since they can give and teach nursing as well as physical therapy for patients who require both services, and they can be responsible for family health supervision in homes in which physical therapy is given and can give general nursing in an emergency.

In the light of recent developments, many agency directors are beginning to question the validity of all of these points. Public health agencies employ nutritionists, social workers, and personnel in other allied fields who are not nurses. They ask whether there is any reason why the physical therapist without nursing background cannot function equally well? In fact they wonder whether the physical therapy service might not be stronger if the physical therapists were not called upon to meet emergency demands of nursing.

The present trend in state agencies for crippled children is to employ a consultant in physical therapy with major attention to her qualifications in that field and to employ also a consultant in nursing because it has proved difficult for one person to represent two professional fields.

With these changes public health nurses are beginning to ask whether there is a place for them in physical therapy and for how long.

The answers to these questions depend upon many factors. It is the opinion of the writer that this is a transitional period and that for the next five to ten years progress in correlation of nursing and physical therapy can be more rapid, and effective orientation programs for physical therapists in public health developed in a shorter time, if a limited number of public health nurses continue to become qualified in physical therapy.

The nurse who seeks preparation in physical therapy, however, should recognize that she is entering another profession but that it will also give her background which will enable her to help improve the quality of nursing in an area which has hitherto been weak—body mechanics and posture. Even though dual preparation may not be a requirement in the future, the nurse who becomes qualified in physical therapy need fear no discrimination in employment provided she is well prepared in physical therapy.

Because of the shortage of physical therapists, it is important that all qualified workers be used to the best advantage, and that new field services when needed not be postponed

because it is impossible to secure a physical therapist who is also a nurse.

Some of the factors which will enable physical therapists without nursing background to work more effectively in public health agencies are: (1) better understanding on the part of nursing directors and staff of the agency of the service the physical therapist is prepared to give and of how to interpret their needs to her (2) adjustments in curricula of physical therapy schools which will give physical therapists knowledge of public health administration and a better understanding of normal child growth and development and total patient care and (3) improved methods of on the job orientation.

Field practice in physical therapy in the public health agency. One way in which physical therapists can become better qualified for positions in public health is to have a portion of their clinical practice in a public health agency which can offer adequate supervision. The type of program which has been so ably developed by Mary Macdonald in the Boston VNA in collaboration with physical therapy schools in that area has been used in some other localities and should be developed more extensively wherever resources are available. Supervised experience in the nature of an internship is another effective means of preparing physical therapists for service in a public health agency

Terminology. The three articles on physical therapy services in public health agencies are evidence of clarification of the terms used to describe the service provided and the worker who gives it. In the past confusion has been created among both professional personnel and the public because a field physical therapy service sometimes was called orthopedic nursing and the person giving it an orthopedic nurse even though she might be a nurse who was also fully qualified in physical therapy.

There are various reasons for this. As far back as 1916 agencies such as the Visiting Nurse Associations of Boston, Brooklyn, and Chicago and the New York State Health Department employed nurses whose follow up of poliomyelitis and other patients included massage and muscle reeducation as well as nursing. At that time physical therapy standards of education had not yet developed. For the most part those who carried out procedures now recognized as a part of physical therapy had an apprenticeship type of training built on preparation in nursing or physical education. Therefore, it was only natural that public health agencies which employed nurses a part of whose service included muscle reeducation for orthopedic patients should call these workers orthopedic nurses.

Another reason for the persistence of the terms *orthopedic service* and *orthopedic nurse* as applied to physical therapy and the physical therapist is that many public health agencies have offered a service which included both nursing and physical therapy and in many instances, one person who might or might not be fully qualified in both fields gave the two services to the same patient. Furthermore, since there is some overlapping in preparation and function between orthopedic nurses and physical therapists, time has been required to arrive at agreement in regard to content of the two fields. Two recent studies by the National League of Nursing Education,—"Guide for an Advanced Clinical Course in Orthopedic Nursing" and "The Contribution of Physical Therapy to Nursing Education"—have contributed to better understanding of the scope of orthopedic nursing and physical therapy.

Differentiation between orthopedic nursing and physical therapy. The Joint Orthopedic Nursing Advisory Service has recommended that programs of study in orthopedic nursing which are designed to prepare specialists in that field should include courses in anatomy, physiology, kinesiology and body mechanics, pathology, neurology, and orthopedics comparable to those given in schools of physical therapy. Both services are based on the same principles of physical, biological, and social sciences, although application differs. The orthopedic nurse applies them in *nursing* procedures such as in care of patients in

casts, traction, frames, and braces. The physical therapist applies them in *treatment technics* such as massage, therapeutic exercises, hydrotherapy and electrotherapy. Orthopedic nursing and physical therapy are equally concerned with efficient use of the body in rest and activity, prevention of unnecessary disability, and psychological aspects of care.

Because until recently programs of study in orthopedic nursing have not offered adequate courses in anatomy and kinesiology to give the nurse security in application of principles of body mechanics and posture, many nurses in the past have found it necessary to secure this preparation through courses in physical therapy. As the content of programs in orthopedic nursing becomes strengthened in this area, it should be no longer necessary for nurses to take courses in physical therapy to prepare for orthopedic nursing. In the future we should expect the orthopedic nurse and the physical therapist to be equally prepared to give advisory help to nurses in relation to body mechanics and posture.

The local public health agency which administers a field physical therapy service would naturally look to the physical therapist for this type of consultation and would not find it necessary to employ also a full-time consultant in orthopedic nursing. In such instances it is an advantage to have some of the physical therapy staff qualified in nursing since consultation relates also to nursing of the orthopedic patient.

Well prepared orthopedic nurses in hospitals and schools of nursing are urgently needed for the instruction of student and graduate nurses and there should be administrative planning which will enable them to act in an advisory capacity in relation to bed positions and activity of patients on all clinical services. When both an orthopedic nurse and a physical therapist are employed, there should be a clear definition of the functions of each so that there will not be duplication of advisory service in relation to body mechanics. The physical therapist would be expected to be responsible for advisory help relating to desirable functional activity, exercises for postpartal patients, and passive movements for poliomyelitis patients although the orthopedic nursing instructor might follow up with demonstrations to nurse students.

Opinion differs in regard to desirable preparation of nursing consultants in state agencies for crippled children. It is generally agreed that a good background in public health and pediatric nursing is fundamental to nursing of the orthopedic patient.

Experimentation is now going on in the universities where advanced clinical programs are offered to share courses of common interest. Perhaps a combined program of pediatric and orthopedic nursing with integration of the social and health aspects may prove to meet the needs of nursing consultants in state agencies for crippled children.

Because in the past facilities for preparation in orthopedic nursing have been limited, in some states preparation in either physical therapy or orthopedic nursing has been considered acceptable for orthopedic nursing consultants employed in state agencies. For the nurse who is a qualified physical therapist but is employed in another capacity such as a nursing consultant, her function and responsibilities will be clarified if the title designating her position specifies orthopedic nursing rather than physical therapy. The physical therapist with nursing background who is employed in a dual capacity may use both RN and RPT to clarify her function and preparation.

Need for special studies in relation to physical therapy programs in public health. In both the Boston VNA and the New York State Department of Health, nurses give physical therapy to selected patients under supervision of the physical therapist. Miss Macdonald particularly has made out a strong case for this plan.

In other places some agency directors and physical therapy staff consider that this plan is not economical and does not make for the best use of these two professional services. If the nurse is to give some physical therapy, time of nurse and physical therapist is re-

quired for in-service education and frequent field visits for demonstration and supervision. Since the amount of in-service education is limited, they contend that time which should be given to help the nurse apply principles of body mechanics and posture to all nursing and to assist her to carry out supportive nursing measures for the patient who receives physical therapy must be diverted to enable her to carry out physical therapy procedures. Those who hold this opinion doubt whether time is actually gained through this method and question whether the patient receives the best quality of physical therapy. Another controversial question is how much health supervision should be expected of the physical therapist who is not a nurse.

Although flexibility in agency programs is desirable it would seem that further study of administrative policies should be encouraged.

Summary. Physical therapy under medical prescription and direction should be more generally available to patients in their homes. The public health agency which serves all age and diagnostic groups in the community should preferably administer such a service. Personnel fully qualified in physical therapy should be employed but it is not necessary that they all have nursing background. Physical therapy schools should consider adjustments in their curricula including clinical practice which will prepare physical therapists for service in any type of community agency including public health. Public health agencies employing physical therapists should plan an orientation program which will enable them to make their maximum contribution as members of the professional team. Physical therapy schools and public health agencies with field services in physical therapy should work together in planning supervised experience in physical therapy under qualified supervision in the public health agency whenever such arrangements are practical.

Physical therapists who are also public health nurses can contribute in promoting better understanding of these two professional services and will be needed in selected situations, particularly during transitional years.

The terms used to describe services offered by an agency and the personnel giving them should indicate the nature and scope of the services provided. The terms physical therapy and orthopedic nursing should not be used interchangeably.

Special studies are needed in regard to agency policies concerning physical therapy services to determine methods which will best serve the patient and make most economical use of professional workers.

EDITOR'S NOTE– Miss Stevenson's article is the fourth in a series discussing physical therapy services in public health agencies. Letters from the field indicate that there has already been lively discussion of the points raised. We hope that the series will continue to stimulate staff conferences. Providing for patients' needs, preparing or finding personnel to provide physical therapy services, sharing information and preventing duplication are the concern of all public health agencies. Establishing or supplementing services requires discussion of policies, cooperative planning, and interchange of ideas.

Staff conferences will reveal problems related to physical therapy services that have not been discussed in these articles which may need further exploration. Or they may suggest that clarification of certain points, other points of view, or description of still different programs should be published in later issues of PUBLIC HEALTH NURSING. Suggestions, opinions, or questions may be sent to the Joint Orthopedic Nursing Advisory Service.

A reprint of the four articles may be obtained without charge by writing to JONAS, 1790 Broadway, New York 19, N. Y.

AN ARTICLE about visiting nurses appeared in the December 1948 *Ladies Home Journal*. Be sure to read it because although written for the general reader it has interest also for nurses. In a few hundred words, Margaret Hickey, editor of the *Journal's* Public Affairs Department, tellingly summarizes facts secured from NOPHN and other authoritative sources. She follows with her impressions of the New Haven VNA. Certainly thousands of Americans now know more about public health nursing than they did before this informative article appeared.

If you like what you read, let the *Ladies Home Journal* know, since you will recall many nurses wrote expressing concern about a previous article, unsympathetic to their profession.

THE NURSE IN A MENTAL HEALTH CLINIC

ADELE HENDERSON, R.N.

MENTAL HYGIENE consultants are not new in the public health field, but few nurses have been found up to this time as members of mental health clinic staffs. Under the expanded activities made possible by the passage of the National Mental Health Act, a provision was made to utilize mental health nurses in various community mental health clinics. With the establishment of the first Public Health Service demonstration clinic, a nurse was assigned as a full-time staff member, augmenting the usual team of psychiatrist, psychologist, and psychiatric social worker. Interest has been expressed in the functions of the nurse in this clinic.

In January 1948, the Maryland State Department of Health announced the opening of the Prince George's County Mental Health Clinic, a demonstration of the Public Health Service Mental Hygiene Division. Preceding the opening date of the clinic in College Park, Maryland, county residents made active plans by forming an Interim Board. In February an open community meeting was held, at which time an Advisory Board was chosen and a constitution adopted. Members of the Advisory Board represent community health, welfare, and educational organizations interested in the county mental health program. Meetings are held monthly to assist in any way possible in promoting the working relationship between the clinic and other community agencies.

Mrs. Henderson is the mental health nurse in the Prince George's County Mental Health Clinic, College Park, Maryland

The purpose of the demonstration mental health clinic is research into technics of earlier case-finding and types of coordinated community activities which may lessen the incidence of mental illness. As in most psychiatric and mental health clinics, individual study and treatment are essential parts of the program. Each patient is seen as part of a family and community group; and his problem as a result of stresses within his group. Objectives of the Prince George's County clinic include more than service to the individual patient. How service can be extended into the community has been studied intensively. While handling individual problems brought to the clinic, the chief focus is on educational functions in the community. Parents, teachers, and potential teachers have been reached through the participation of clinic staff members in meetings of individual PTA groups, the County Council of PTA, University of Maryland, and Bowie State Teachers College seminars, nursery school teacher groups, the Annual Parent Institute in the county, various women's and civic organizations, and mothers attending maternal and child hygiene clinics.

NURSES AND MEMBERS of other disciplines are wondering how the nurse fits into this picture. What are her functions as a member of a community mental health clinic staff? This is a progress report and not something final, formulated and tied into the legendary bundle. The assignment presented itself as a step toward determining the con-

tribution nursing service could make in this specific situation. Provision had been made to include a public health nurse with psychiatric orientation on the clinic staff, but no pattern had been cut nor standards set. The six-month period of working with a cooperative and understanding clinic group has been a process involving thoughtful consideration, exploration, and experimentation in outlining the area for the nurse.

Under the direction of the psychiatrist, the mental health nurse has participated in the treatment of selected patients and patients' families by giving nursing service in the clinic and in the home. Nurses in the field of public health have made a place for themselves in communities and have gained entry into family groups because they have carried their knowledge and skills into the home. Long ago families accepted the personalized service of a nurse from the public health agency. Home visits from a nurse in the mental health agency have been received with the same natural acceptance. The selection of patients assigned to the nurse was determined by the staff in treatment conferences and was based on the contribution to the therapeutic plan that could be made best by a person with nursing education and experience. Home visits have been dependent upon an individual patient's problem and the circumstances involved. Decisions as to when a visit is indicated, and by which staff member, are made in treatment conference.

Home nursing visits were believed advisable for one patient who was being seen weekly by the psychiatrist in the clinic. The patient said she felt depressed and unhappy periodically, and she showed many hysterical symptoms. Periods of sleeping during her depressed states were described. An opportunity to observe the picture she presented came when a concerned neighbor telephoned to report she had been unable to arouse the patient from an 18-hour sleep. A nursing visit was made to the home. The general condition of the patient was observed: color, pulse, respiration, pupillary reaction to light, and a stiffness in the legs that suggested a voluntary stiffness. The nurse talked quietly to the patient while bathing her face; an answering response was seen in the flickering of the patient's eyelids. The neighbor was reassured that no harm would result from allowing the patient to remain in her sleeping state. Talking with the husband revealed his attitude toward his wife's illness as well as his acceptance of a nursing visit as an aid in the psychiatric study and treatment of his wife. The home visit presented an opportunity to talk with the 9-year-old daughter who hung in the background, watching her mother intently with an anxious expression on her face. Her question "will my mother never wake up?" offered a chance to give her reassurance at the moment of her anxiety.

IN ALL HOME nursing visits the focus is on the need of the patient; this need may be an emotional one as well as physical. A public health nurse, visiting a mother with a new baby, might find this mother more preoccupied with a 5-year-old boy in bed with an elevation of temperature than with the routine of bathing an infant. If the mother's concern is recognized as something that affects her baby, her 5-year-old, and herself, the nurse will begin with the older child rather than first conscientiously giving a bath demonstration.

The mental health nurse visited the home of another disturbed mother under psychiatric care who seemed unable to make decisions relative to her children and who needed support and assistance in everyday household matters. During the visit the nurse sensed the mother's concern over the comfort of her two children in bed with measles. Working with the mother in giving the children bedside care provided a bond between the mother and nurse and at the same time gave supportive care to the mother. Weekly nursing visits offered a listener to whom the mother could talk about anything that concerned her. Often she needed help in problems of child development, behavior, and care.

The mental health nurse has had the opportunity of participating in weekly staff conferences. The afternoons set aside for staff meetings have included case conferences with referring agencies, discussions with offi-

cial visitors interested in the functions of the clinic, and case discussions. At three such conferences a patient presenting a picture of anorexia nervosa was discussed by the staff. The patient felt that she was able to swallow only after her night's rest and following an afternoon rest period. She had lost considerable weight but showed no other evidence of nutritional deficiency. During the third staff conference a plan was advanced to use nursing visits in helping the patient with her dietary problems. Acceptance of the patient's ability to eat a limited amount of food enabled the nurse to plan with the patient a diet including the most nourishing foods. The focus was on the patient rather than on specified nutritional requirements. Any suggestion encouraging change in food habits would have intensified or prolonged the existing problem.

Liaison with other community nursing groups has been a primary function of the nurse in the clinic. Consulting with other public health nurses on patients to be referred for clinic study included visiting homes with the nurses.

The clinic goals directed toward prevention of emotional problems recognize the possibilities presented in the field of maternal and child health. Public health programs have demonstrated the value of preventive measures in prenatal clinics and well baby conferences. In many areas of the United States progress in health education has been observed in parents' acceptance of the importance of prenatal medical care, medical examination of the well child, and immunization. If physical, mental and emotional health are regarded as inseparable, much can be done to make this prophylactic effort more complete. Parents can be helped to deal with everyday problems of living with a minimum of anxiety; help can be given in such childhood matters as feeding, toilet habits, play, sex education, health and illness. The nurse sees a child and his family before the child has reached school age; nursing contacts begin with prenatal patients and afford a glimpse into the family life before a child is born. Helping a parent understand the psychological as well as the physical needs of his child must be included in public health nursing service.

SEVERAL MONTHS AGO, mothers discussion groups were initiated in two of the six maternal and child hygiene clinics in the county. The purpose of the groups is to give mothers and expectant mothers the opportunity to verbalize their feelings, ideas, and problems in infant and child care. The groups are in a beginning stage, and spontaneous group conversation in a clinic setting is new to many mothers. Group composition varies, dependent upon clinic attendance. In several instances group discussion has acted as a screening device for subsequent individual discussions.

Although the newness of the project makes a complete report impossible, certain experiences are interesting. Following a discussion of infant feeding, one mother offered her discovery to the group. She had found a little book in the drug store that had been "a big help" to her, *Baby and Child Care*, by Dr. Benjamin Spock. Might not a recommendation from another mother be more effective for some mothers than such a reading suggestion from the nurse?

One mother told the group she liked to breast-feed her babies, because it made her "feel close to the baby." This seemed a clear expression of the relationship value of breast feeding from which others present might benefit. A second mother commented that she bottle-fed her baby and seemed interested when the idea was offered that the act of holding her baby during the feeding period offered similar opportunity for a warm relationship. Some mothers might be unaware of the emotional deprivation that could result from the use of intriguing new bottle-holding devices manufactured to make baby care more "convenient."

Observation of one group of mothers has shown a remarkable lack of converts to the previous strict ideas of absolute regularity in feeding methods. They seem to have retained their belief that babies are reliable in indicating their own caloric needs and regulating their own mealtime schedules. The ex-

perience of these mothers reassured others who had felt that perhaps they ought to be adhering to rigid feeding schedules.

In discussing bowel and bladder control, one mother said she could not understand why her 11-month-old child sat on the toilet, did nothing, and proceeded to soil her diapers shortly thereafter. Another mother commented that the child might be more accustomed to the diaper method, and a discussion was launched on the individual child's readiness in learning toilet habits. Mothers seem interested in explanations of the physiologic development of bowel and bladder control. If parents know that children must understand to cooperate and that the maturation of bladder function and the development of bowel control play a large part in the process, they might be less inclined to manage the situation by going about it in a fanatic "this is something to be taught" manner of doing.

It is believed that mothers can gain by expressing their ideas and feelings in a group and can learn from the experiences of others. Groups have varied, but the level of interest in sharing experiences with a group and with the nurse has not varied, regardless of the composition.

The field for mental health nurses has been accented. Six months has provided some idea of nursing functions and road signs toward others. All nursing groups have an active role to play in working toward the goal of optimal physical, mental, and emotional health. Mental health nurses add to the team effort toward health for the individual and for the community.

ANNOUNCEMENT OF REGULAR CORPS EXAMINATION FOR NURSE OFFICERS

United States Public Health Service

A competitive examination for appointment of nurse officers in the Regular Corps of the United States Public Health Service will be held on March 17 and 18, 1949, at various points in the United States.

Appointments are permanent in nature and provide opportunities for a lifetime career in the fields of clinical and public health nursing at Marine Hospitals, and in a variety of public health programs.

Appointments will be made in the grades of Junior Assistant (corresponds to 2nd Lt.), Assistant (1st Lt.), and Senior Assistant Nurse Officer (Captain). Annual entrance pay is from $2955.50 to $4489.00 as determined by the grade of appointment and existence of dependents. All applicants must be registered nurses with a baccalaureate degree from an approved school of nursing. (Past nursing experience in the Army, the Navy, or the Public Health Service may serve, in certain instances, in lieu of academic degree).

Additional information and application forms may be obtained by writing to the Surgeon General, United States Public Health Service, Washington 25, D. C., Attention: Division of Commissioned Officers. Completed applications must be received not later than February 17, 1949.

TRENDS

in Medicine and Public Health

DIETITIANS AS TEACHERS

Nurses will find food for thought in Cyril O. Houle's article in the *Journal of the American Dietetic Association*, October 1948. He writes "the main goal of the dietitian is to change the behavior of people," and to do that the dietitian must be a teacher. She should neither act in terms of her own feelings nor should she have a desire only to provide technical information, but she should be "concerned with making the contact profitable to the patients by developing their understanding of diet." The dietitian who wishes to improve her teaching skill should read widely in the field of educational psychology and method.

Mr. Houle lists five basic steps through which all teaching proceeds. They are: (1) selection of the goal to be reached—the specific goal whose gradual attainment leads to the general goal (2) selection of suitable subject matter (3) organization of the subject matter for most effective presentation (4) application of the best methods of presenting material to students—discussion, lecturing, demonstrations, et cetera, and (5) evaluation —were the goals reached and does the "patient" practice what he was taught?

Although the five steps are all important, Mr. Houle states that method is "the heart of the process of teaching." Regardless of the technics which the teacher may use, the interpersonal situation between teacher and student must be one conducive to learning. Certain elements are present in good learning situations: Is the path of progress open to each student? Is the social atmosphere a pleasant, friendly one? Is each student kept informed of his progress?

"Teaching is best when it is naturally, not self-consciously, undertaken." The only way to achieve this natural ability is through the route of conscious thought. Constant reexamination over a period of time of one's own teaching methods and performances will make the principles inherent in one's teaching behavior.

CANCER CONTROL METHODS

Cancer control methods in Connecticut are evaluated by Matthew H. Griswold, in *Journal of AMA*, November 20, 1948. Public health nurses will recall an earlier article in PHN, April 1946, in which the author described the functions of their particular professional group in the Connecticut program, namely in case finding, follow-up, nursing care at home, mental hygiene, and in arranging social adjustments.

Dr. Griswold reports some of the results attained since 1935. (1) The age-adjusted male cancer death rate has risen during the 12-year period, but appears to be leveling, while the female age-adjusted cancer death rate has fallen. (2) The incidence rate has increased with consistency, reflecting the improvement in services rendered to Connecticut people by every new measure introduced to increase the understanding of cancer.

Follow ups over a long period of time are essential if accurate appraisal is to be attempted. When the system became general it was found that 1,500 patients treated for cancer from 1935 through 1940 had had no follow-up treatment from the time of their discharge after the initial treatment. Since then, however, the proportion of untraced cases has been so small that fewer than 5 per-

cent of the nearly 38,000 cases in the registry have been lost to follow up.

One of the most encouraging features of the Connecticut registry which includes active follow-up of all living patients is the fact that a large number of persons have survived treatment for cancer for more than five years. Survival largely hinges on how early treatment is begun. The greatest increase in those that come for treatment as soon as they notice symptoms has been among persons with cancer of the respiratory tract, skin, rectum, buccal cavity and stomach, in that order. Greatest improvement in the adequacy of medical advice has been among patients with cancers of the breast, stomach, and other digestive organs and genitourinary system. The reduction in delay due to negligence and ignorance has been most pronounced in persons with cancers of the rectum, genitourinary system, other digestive organs and respiratory tract, in that order. An increase in 1946 is noted in delay due to negligence on the part of patients with cancer of the skin.

A study of patients alive at yearly intervals following treatment shows steady improvement in survival from 1935 through 1945, indeed spectacular improvement during the latter years.

Dr. Griswold concludes his report with the statement that "to know the size of the problem, to have an established follow-up system, to have available diagnostic and therapeutic resources, to have an alert medical profession and an aroused laity and to have a division of cancer control capable of tabulating and analyzing these factors are all prerequisites to the final evaluation, which is measured in lives saved, in improving the rate of survival."

NUTRITION IN DENTAL EDUCATION

"A practicing dentist should have a sound background in the fundamentals of nutrition, theoretically, because he should have a broad knowledge of the body as a whole, and practically, if he is to be adequately prepared to take an active role in the utilization and extension of nutritional knowledge in his particular field of public health." Dietary control seems to be one of the most promising ways for the prevention of dental caries. The soft tissues of the mouth are among the first to show signs of nutritional deficiencies. They are vitally influenced by diet during growth and constantly changing with the metabolic status of the body. Restorative dentistry in the hands of dental personnel now available can eliminate hardly more than 25 percent of the caries known to exist in the United States. These conclusions are stated by James M. Dunning and James H. Shaw in the November 1948 *Nutritional Reviews* in a review of recent literature on this subject.

Recent surveys have shown that only a handful of dental colleges offer courses in nutrition, with relatively little time spent in teaching these courses. The American Association of Dental Schools through its Curriculum Survey Committee has made recommendations not far in excess of the amount of nutrition actually taught. The committee did not feel that a dentist should be qualified as or presumed to be an expert nutritionist, nor that he should prescribe definite dietary programs for his patients. They did feel he should have a working knowledge of general principles in order to recognize outstanding dietary faults, and in conjunction with a pediatrician or physician, suggest a corrective diet.

The result of this limited nutrition teaching in American dental schools has produced approximately the expected effect. Most dentists know the theoretic importance of nutrients like calcium and vitamin D, but few question their patients routinely about their diet and almost none can or desire to take diet histories, assist patients in planning good menus, and counsel them in regard to food habits. Many dentists feel that the highest function a dentist is likely to be able to attain is that of recognizing and filling new lesions of dental caries at the earliest possible moment.

It seems proper to the writers that at least twice as much time be devoted to nutrition in dental teaching than is now recommended by the American Association of Dental Schools.

ALUMINUM FOIL FOR BURNS

A group of Canadian doctors have been experimenting with thin aluminum foil in the treatment of severe burns. Used in 50 test cases last year, successful results were obtained in 49 of them. The experiments brought out that less time and effort is required to apply foil than sulfa ointments; pain disappears shortly after application; surgical shock is reduced; infection is reduced or eliminated.

Foil is applied as follows: The foil is sterilized before using. The burned area on the patient is washed with antiseptic detergent and loose dead skin is removed. The area is dried with a sterile towel and the foil is then applied directly to the burned skin. The foil is covered with a thick layer of non-absorbent cotton wool to which in turn is applied a flannelette pressure bandage. The burn is redressed in 10 days.

Dr. A. W. Farmer, Hospital for Sick Children in Toronto, Dr. W. A. Brown and Dr. W. R. Franks, of the Royal Canadian Air Force, mention factors which may account for the favorable results of the use of aluminum foil. (1) Because of its heat reflecting properties, aluminum foil conserves the body's heat. (2) By providing a physical barrier, the foil appears to prevent leakage of a vital body fluid containing protein to a greater degree than other forms of local therapy.

SOCIO-ENVIRONMENTAL FACTORS AND HEALTH

The association between physical environment and certain diseases is the foundation on which the public health program was built. In the first of three articles appearing in the October 1948 *Milbank Memorial Fund Quarterly*, Dorothy G. Wiehl discusses the relationship between mortality and the socio-environmental factors. She points out that while death rates in all parts of the United States have declined sharply in the past half century, the decline has not been at a uniform rate. Drops in mortality have been greatest for children and young adults in large urban centers, where medical and public health services are well developed and easily available. Preventable mortality among children is relatively high in rural communities of most sections of the United States and is high in the smaller cities of the South. In middle life, urban males have a marked excess mortality as compared with females, and the difference has been increasing. Although the excess for mortality for rural males is less, it has been increasing also. Geographic and urban-rural variations in adult mortality and in the differences in the sex-ratio for adults suggest the importance of socio-environmental factors. The causes of premature breakdown in middle life, especially for males, need to be studied more intensively.

The second article, by Jean Downes, is a study of the relationship between the social and environmental factors and illness. Information was obtained on certain aspects of the environment of the family, such as age and sex of the population under consideration, size of community, income, amount of rent or value of owned houses, data on housing conditions, occupations of employed members of the family, educational level of family members, and whether or not the family had moved to the city from the farm during the 10 years preceding the survey.

Miss Downes reaches the conclusion that economic status as expressed by annual income of the family is an important index of environment because it determines to a considerable extent the poverty or abundance of so many conditions conducive to healthful living: food, housing, medical care, education, and recreation. However, the author states "the relationship of family income to all illness is clearcut only for the very poorest, those with an annual income of less than $1,000." This is partly due to the fact that respiratory diseases and acute infectious diseases constitute a large proportion of *all illness*, and these are common to all population levels. However, when such diseases as pneumonia, rheumatic fever, or tuberculosis are considered, their relationship to poor environment as defined by annual income is more clearcut. Poor environment apparently tends to lower nonspecific resistance to these and other diseases and thus is an active factor

in their production. We do not know the particular factor or factors responsible. The relationship of family income to *all chronic diseases* also is clearcut only for the very poorest groups in the population.

The study of morbidity in relation to social and environmental indices is of value because it indicates what part of the population is most in need of public health and medical care. However, we need to evaluate the precise influence of specific environmental conditions in producing ill health.

Rollo Britton's article is concerned with the relationship between the socio-environmental factors and physical impairments. The author reviews data from surveys and from health examinations, but points out the dangers in these figures because of their abstract character and the fact that they minimize disparities because they neglect quality and seem but a pale expression of the tragedies that lie behind them. But in spite of the ambiguous nature of the data on the association of physical impairments and socio-environmental factors, Mr. Britton concludes: (1) Serious impairments result in lower economic status. (2) This relation is true even for impairments in a group of people able to be about. (3) To an important extent, the components of low economic status are causes of physical impairments, forming a vicious circle. (4) Certain elements in the environment are particularly significant in this connection, such as occupation, housing, and insufficient medical care.

"SUBSTITUTE MOTHERS"

A group of volunteer workers at Bellevue Hospital, New York City, minister to the recreational and emotional needs of children by playing and talking with them, listening to their troubles, and giving them the encouragement considered by doctors to be as important as medicine in getting a sick child well. These volunteers are for the most part working women who are busy during a good part of the day, according to *Better Times*, December 3, 1948.

"Hospitals damage children," explained Dr. John Osborn of the Bellevue staff. "The healthiest child can be made ill by prolonged stay in even a good hospital. But the substitute mothers counteract the emotional deprivation which makes for illness."

EMERGENCY TEACHER TRAINING

A plan worked out in England, as part of the British Education Act of 1944, for the training of teachers in a single year to aid in the alleviation of the postwar shortage of approximately 100,000 teachers is commented upon in the October 1948 *Newsletter* of the Council on Cooperation in Teacher Education.

The essential feature of this scheme, according to the report from the Ministry of Education, "is the provision of intensive 1-year courses for candidates over 21 who have been engaged in some form of national service during the war. These courses lead to the status of qualified teacher, approval being based on the satisfactory completion of the course and a careful assessment by the college staff, and not on any formal external examination."

Questionnaires circulated among the emergency teachers and interviews with both students and college faculties seem to indicate that teachers themselves are satisfied as well as principals of the colleges where they are prepared, and headmasters of the schools where they are now engaged. These people agree that, with due consideration for their shorter experience, these teachers compare favorably with their colleagues in the professional ranks. With respect to academic standards, the emergency-trained teachers as a group are not quite as strong as their colleagues from the 2-year training colleges and the university departments of education. This matter it is felt can be rectified by their strong sense of vocation and wise use of the 2-year part-time study period planned to follow the training period. Careful selection of candidates, a problem-solving type of curriculum and much individualized instruction, and superior motivation of students and staffs, have been the main factors leading to the success of this scheme.

NEW BOOKS

PSYCHIATRY IN A TROUBLED WORLD

By William C. Menninger. New York, Macmillan, 1948. 636 p. $6.00.

This book is an effort of the author who was war-time chief consultant in neuropsychiatry to the surgeon-general of the U. S. Army, to bring before the public a clear picture of the Neuropsychiatric Division's activities and findings in our armed services and to point out the chief implications of our wartime psychiatric experience for postwar living. Written in language that is understandable by both lay and professional readers this book contains a wealth of information which will do much to help the reader to a clearer understanding of the veteran and those stresses and experiences which contributed to his mental health or ill health.

Part I deals with the status of psychiatry both in the army and the community at the beginning of the war, the problems of organizing an adequate psychiatric service, factors in the soldier's personality which succeeded or failed in responding to the emotional supports provided or the stresses and strains experienced, clinical observations, and the administrative practices used in treatment or disposition of patients.

Part II concerns the wartime lessons learned and their implications for civilian medicine, education, industry, criminology, and research. With public interest in problems of mental health at an unsurpassed level in our country, Dr. Menninger's report is most timely. This book cannot fail to be of real value to nurses who are seeking a better understanding of the problems of mental health and assistance with interpretation to patients and the community.

—Helen W. Bowditch, R.N., *Acting Director of the Advanced Clinical Program in Psychiatric Nursing, Boston University School of Nursing, Boston, Massachusetts.*

EATING FOR HEALTH

By Pearl Lewis. New York, Macmillan, 1948. 121 p. $2.25.

This small volume might well occupy a place on the bookshelf of any home beside the favorite cook book, the first-aid manual, the dictionary, or any regularly consulted reference. It presents facts vital to the family's health in a concise, understandable, and interesting form. It is neither glamorized by sketches and "catchy" phrases, nor is it too scientific for the laity, but is presented in logical sequence and in simple, readable terms. It contains all the information necessary for the individual or the family to know about good nutrition for healthful living.

—Marie Sisson, *Dietitian, Edward J. Meyer Memorial Hospital, Buffalo, N. Y.*

TEACHING PSYCHOTHERAPEUTIC MEDICINE: AN EXPERIMENTAL COURSE FOR GENERAL PHYSICIANS

Edited by Helen Leland Witmer. New York, The Commonwealth Fund, 1947. 464 p. $3.75.

The reviewer of this work can succinctly characterize this contribution as a "must" not only for practitioners but members of the nursing profession. It is indeed a challenging and stimulating experiment in vitalizing a technic of teaching principles of psychotherapeutic medicine. This workshop method offers a potential device which could be used with medical students and nurses in calling attention to the significance of interpersonal relationships and their effect on human behavior influencing both psyche and soma.

Twenty-five representative physicians from Minnesota and nearby states studied for two weeks, with seven psychiatrists and two internists, the "meaning and value of patient-physician relationship, the natural history of the personality, the significance of psycho-

neurotic behavior, and the ways in which everyday practice can be made more helpful and more rewarding by simple psychotherapy —in brief, the art of helping people whose trouble is emotional as well as physical." This orientation will overcome many of the resistances and prejudices regarding the treatment of psychiatric problems, the unfortunate history of which has been due in large measure to the indoctrination that psychiatry consists of seeing a patient wheeled into an amphitheatre restrained in a straitjacket, screaming invectives and delusions.

These patients were treated for everyday complaints that are ordinarily so difficult to deal with—headache, indigestion, backache, vague with persistent pains, fatigue, and nervousness. The consensus of opinion of these representative physicians was that they required greater understanding of human emotions and the physical expressions of emotional tension. There are significant chapters on History-taking; Patient-physician Relationship; Normal Personality Development; Meaning of Psychoneurosis; Diagnosis of Psychoneurosis; Anxiety; Psychotherapy; Common Psychopathology; Life Situation; Emotions and Disease, et cetera. In a short space one cannot do justice to the rich material, its meaning for medical education and therapy, and the implications for further similar studies.

—Louis A. Schwartz, M.D., *Chief, Division of Neuropsychiatry, Women's Hospital, Detroit, Michigan.*

ESSENTIALS OF NURSING

By Helen Young, Eleanor Lee, and Associates. 2nd ed. New York, G. P. Putnam's, 1948. 556 p. $3.75.

The second edition of this textbook marks two anniversaries,—publication of its predecessor five years ago, and of *A Textbook of Practical Nursing* by Anna C. Maxwell and Amy E. Pope, 40 years ago.

Revision of the text includes the addition of new procedures, diagnostic tests, and therapeutic measures. New illustrations have been added and some of the line drawings have been revised to include the principles of posture and body mechanics for the nurse and the patient. The content has also been reorganized and new sections have been added to meet the increasing demand for consideration of total care of the patient, mental, emotional, and social as well as physical. This edition, however, still places all of its emphasis upon the physical care of the patient in the hospital. It seems to this reviewer that its organization could be improved and its usefulness to students increased by including the content of Part IV—Adaptations of the Basic Principles of Nursing Care in Part II—Basic Nursing Care. In teaching nursing, it is logical to consider the adaptations at the time the nursing care is discussed or demonstrated, and it is irritating to the reader to be turning pages from one part to the other.

This book's chief value is in the clear, concise presentation of hospital nursing procedures and the underlying scientific principles.

—Julia Hereford, R.N., *Associate Professor of Nursing, Vanderbilt University School of Nursing, Nashville, Tennessee.*

THE DIABETIC'S HANDBOOK

By Anthony Sindoni, Jr. New York, The Ronald Press, 1948. 194 p. $3.00.

Dr. Sindoni dedicates his handbook "To the diabetic who realizes that he need have nothing to fear." The whole purpose of the book is to help the diabetic face his disease objectively.

In the first section of the book, the author answers the general questions which arise when the individual learns for the first time that he has diabetes. On the whole, this technic is helpful.

Complications in diabetes are well presented by specialists in the different fields. Nurses will find this material of value as unusual as well as common conditions are discussed. There is a question whether the diabetic may not find the listing of complications, which he may or may not develop, somewhat frightening.

The last portion of the book deals with methods of administration of insulin, with the tests for sugar, and with the problem of diet in diabetes. Menus and recipes are worked out with imagination using a wide variety of foods, and should be especially helpful to the patient and his family in their first encounter with a restricted diet.

The handbook is compiled from wide experience with diabetics and is written with a sympathetic approach to their problems as individual human beings. The author stresses the significance of diabetes as an increasingly important public health problem. Public health nurses will find the book a good source of reference and of special value for the comprehensive treatment of diabetes in pregnancy and childhood.

—CHARLOTTE HASSELBUSCH, R.N., *Educational Director, Instructive Visiting Nurse Society, Washington, D.C.*

RURAL HEALTH AND MEDICAL CARE

By Frederick D. Mott and Milton I. Roemer. New York, McGraw-Hill, 1948. 608 p. $6.50.

This book contains a wealth of basic information necessary for an intelligent approach to the problems involved in the improvement of health in the large rural area of the United States. The authors deal with rural America, present-day levels and trends of rural health, rural doctors and other health personnel, rural health facilities, medical services and expenditures, governmental efforts to improve rural health, voluntary health programs, and the road ahead. The book is exceptionally well documented with 1,126 citations of sources conveniently distributed so that each reference is given on the pertinent page of text. The authors present critically an integration of the essential facts derived from many studies of health and medical care. In the last part of the book Doctors Mott and Roemer advocate universal compulsory health insurance,—which is a controversial method of solving the problems presented.

—ARCHIBALD S. DEAN, M.D., *Regional Health Director, State Department of Health, Buffalo, New York.*

PUBLIC HEALTH ENGINEERING

By Earle B. Phelps. New York, John Wiley & Sons, 1948. 655 p. $7.50.

The author has brought together in one book, the underlying principles of the elements of sanitation with which he deals. Part one, The Air Contact, includes chapters on housing, ventilation and air conditioning, lighting, atmospheric pollution, noise, and insect and rodent control.

Part two, The Water Contact, covers water, as to sources, protection, treatment, distribution, uses, removal from the community, treatment and final disposal of human and industrial wastes with which used water is combined.

Part two includes a final section on rural sanitation, which is given minor significance in comparison with the kind of treatment accorded other sections. The book is well illustrated with tables, charts, cuts, and line diagrams.

Pertinent areas of physics, biology, chemistry and other basic sciences, involved in the scientific basis of the phenomena and practices discussed, are abstracted and correlated with the main subject material.

An outstanding characteristic of this work throughout, is the manner in which the relationship of the elements of environment, and their manipulation are related to man and his well-being. This is definitely a public health book. Its usefulness is by no means limited to engineers and sanitarians. The author has clearly had physicians and nurses in mind as readers of the material presented.

Throughout the book, those who wish to carry through computations for solution of a problem will find ample guidance in basic considerations and formulae. At the same time the value of the book, as a comprehensive and understandable source of basic information for all workers in the public health profession, is not diminished by the depth of scientific treatment of subject material available for those who wish to use it.

The book is recommended to physicians and nurses as an understandable source of information on the problems of environment. For public health engineers and sanitarians this book is recommended as a basic text, that should be available for constant reference.

Public health workers should be extremely grateful to Professor Phelps for this opportunity to profit by his knowledge and experience gained through years of study, re-

search, and a career of leadership in the field of sanitary science.

—H. E. MILLER, *Resident Lecturer in Public Health Engineering, University of Michigan, School of Public Health, Ann Arbor, Michigan.*

CORRECTION

An error in the November issue on page 563, has been brought to our attention regarding the price of *Public Health Law* by James A. Tobey. The correct price is $4.50.

And other publications

NURSING EDUCATION

INTRODUCTION TO MATERIA MEDICA AND PHARMACOLOGY. Elsie E. Krug and Hugh Alister McGuigan. 5th edition. St. Louis, C. V. Mosby Company, 1948. 558 p. $4.00.

PEDIATRICS FOR NURSES. Arthur G. Watkins. Baltimore, Williams & Wilkins Company, 1948. 192 p. $3.50.

LABORATORY MANUAL IN ANATOMY AND PHYSIOLOGY. Caroline E. Stackpole and Lutie C. Leavell. New York, Macmillan, 1948. 216 p. $2.00.

CHEMISTRY IN NURSING. Raymond E. Neal. New York, McGraw-Hill, 1948. 564 p. $4.00.

LABORATORY CHEMISTRY FOR STUDENTS OF NURSING. Eleanor M. K. Darby. New York, G. P. Putnam Sons, 1948. 101 p. $2.20.

MATHEMATICS OF SOLUTIONS AND DOSAGE, INCLUDING SIMPLE ARITHMETIC. Margene O. Faddis and Herschel E. Grime. Philadelphia, J. B. Lippincott, 1948. 127 p. $1.50.

PRIMARY ANATOMY. H. A. Cates. Baltimore, Williams and Wilkins Company, 1948. 478 p. $6.00.

MICROBIOLOGY AND PATHOLOGY. Charles F. Carter. 4th edition. St. Louis, C. V. Mosby Company, 1948. 845 p. $5.00.

TEXTBOOK OF ANATOMY AND PHYSIOLOGY. Diana Clifford Kimber and Carolyn E. Gray. 12th edition. New York, Macmillan Company, 1948. 773 p. $4.00.

CHILD CARE

UNDERSTANDING YOUR CHILD—FROM 6 TO 12. By Clara Lambert. 32 p. No. 144. 1948. 20c. Public Affairs Committee, Inc., 22 East 38 Street, New York 16, New York.

ADOPTION IN NEW YORK CITY. Prepared by the New York City Committee on Adoptions. Published by the Welfare Council of N. Y., 44 East 23 Street, N. Y. 99 p. 1948. $1.25.

HANDBOOK—FIRST STEPS IN ORGANIZING STATE OR LOCAL CONFERENCES ON PREVENTION AND CONTROL OF JUVENILE DELINQUENCY. Prepared by The Continuing Committee of The National Conference on Prevention and Control of Juvenile Delinquency. Washington, D.C. 1948. 12 p.

ENJOY YOUR CHILD—AGES 1, 2, AND 3. By James L. Hymes, Jr. 32 p. Public Affairs Pamphlet No. 141. Public Affairs Committee, Inc., 22 East 38 Street, New York 16, N. Y. 1948. Price, 20c.

HEALTH EDUCATION

HEALTH INSTRUCTION YEARBOOK, 1948. Compiled by Oliver E. Byrd. California, Stanford University Press, 1948. 320 p. $3.50.

LIST OF SOURCE MATERIALS FOR TEACHERS OF COLLEGE HYGIENE. Compiled by the American Student Health Association with the cooperation of the Metropolitan Life Insurance Company. 40 p. May 1948. Free. Available from the Metropolitan Life Insurance Company, New York.

NUTRITION TEACHING AIDS. Food value charts, useful for teaching nutrition in interviews, are available at cost from the Nutrition Association of Greater Cleveland, Room 1016, 1001 Huron Road, Cleveland 15, Ohio. Each set includes 15 cards—3½ inches x 6½ inches—which illustrate by colored bars the comparative food value of milk and coffee, whole milk and skim milk, fish and meat, et cetera. Single sets are 30c; quantities of 25 or more are 25c a set.

HOSPITALS

COLLEGE CURRICULUM IN HOSPITAL ADMINISTRATION. Joint Commission on Education. Chicago, Physicians' Record Company, 1948. 107 p. $2.00.

PROBLEMS OF HOSPITAL ADMINISTRATION. Joint Commission on Education, Chicago, Physicians' Record Company, 1948. 104 p. $2.00.

MANUAL FOR MEDICAL RECORDS LIBRARIANS. Edna K. Huffman. Chicago, Physicians' Record Company, 1948. 371 p. $4.50.

PUBLIC HEALTH NURSING

CARE FOR THE ILL-AT HOME; VISITING NURSES, NEW HAVEN, CONN. By Margaret Hickey. *Ladies' Home Journal,* December 1948, p. 23, 181, 182.

FROM NOPHN HEADQUARTERS

WORKING RELATIONSHIP—SOPHN AND SNA

A joint statement by NOPHN and ANA of "recommended organization for State Organizations for Public Health Nursing and State Nurses' Associations Conducting an Economic Security Program for Nurses" has been ratified by both the ANA and NOPHN Boards of Directors. It has been sent to the respective state agencies in the hope that it will offer suggestions for fruitful working relationship, leading to an effective economic security program for public health nurses. The statement follows:

The American Nurses' Association and the National Organization for Public Health Nursing jointly propose that in those states where there are SOPHN's both organizations set up a cooperative plan which will make it possible for the state nurses' association to conduct employer-employee negotiations and collective bargaining for public health nurses.

With the development of a comprehensive economic security program sponsored by the ANA and its constituent state organizations, there arises a need for bringing public health nurses into state nurses' associations as a voting unit. To meet this requirement legal counsel has advised that it is necessary that there be a section for public health nurses in the state nurses' associations.

The implementation of an economic security program for nurses, so vitally needed and so important for all nurses, comes at a time when there is serious consideration and planning for a revision of the structure of nursing organizations. Therefore, until such time as a change in the structure occurs, it is important that where SOPHN's are organized they should be retained. In order, however, to make it possible for public health nurses to assist in and benefit from the SNA program of economic security, as well as provide proper legal machinery for this activity, it is recommended that states carry out the following procedure for organization:

Plan of Organization

While continuing the established program of the SOPHN, the nurse members of the SOPHN should join the SNA and become members of the public health nursing section; in the event the SNA does not have such a section established, as members of the SNA they should cause the creation of such a section. When a public health nursing section is established, it is recommended that, in order to promote the fullest degree of coordination between the section and the SOPHN, serious consideration should be given to the advantages of election to office in the public health nursing section of the nurses who hold office in the SOPHN and who are members of the ANA.

The program of the public health nursing section of the SNA will be directed toward the implementation of collective bargaining and negotiations for improved working conditions for public health nurses through the duly authorized agents of the SNA.

This interlocking organization of the two state nursing bodies enables the SOPHN to continue separately its activities directed toward the development of desirable standards for personnel practices of public health nurses through careful study of local conditions based on the desires and wishes of public health nurses. It also provides for collaboration with the SNA in the development of activities relative to collective bargaining and the negotiation of working agreements.

It is felt that any method by which the two state nursing bodies can continue to supplement the work of each other and speak together for all of nursing will be of benefit to both groups in the states and nationally.

NEW MAGAZINE COMMITTEE

The new Magazine Committee, appointed by Ruth Hubbard, president of NOPHN, for the 1948-50 biennial, makes its debut in this issue, on page A4. Selected for special competence in the field of public health nursing and representative geographically of all sections of the United States, this group will help guide policy-making and planning for the magazine, keep the editors in touch with events and trends, help select authors and subjects, and report on new procedures, experiments and demonstrations. The Committee asks for and welcomes the help of all nurses and others interested in public health nursing in the successful completion of their task.

With this issue readers will note that the magazine has been given something of a new look, better paper, greater readability, and a few new headings.

MISS SHEAHAN RETIRES

The retirement of Marion Sheahan as director of the Division of Public Health Nursing, New York State Department of Health occurred on December 31, 1948. Miss Sheahan left immediately for California where she will teach this spring in the School of Public Health of the University of California at Berkeley. Miss Sheahan is a member of the NOPHN Board of Directors and was president of NOPHN from 1944 to 1946.

Mary E. Parker succeeds Miss Sheahan as director of public health nursing at Albany. Miss Parker has been with the Division since 1941.

GENERAL MEMBERS MEET

An all day meeting of the Executive Committee of the Board and Committee Members Section was held on December 3rd at 1790 Broadway, New York City. Mrs. Philip A. Salmon, Vice Chairman, presided. In addition the meeting was attended by Mrs. Philip Eiseman, Cambridge, Mass.; Mrs. Mildred Hatton, Edgewood, Rhode Island; Mrs. John T. Howell, Wilkes Barre, Pa.; Mrs. L. F. Kimball, Manhasset, Long Island, New York; Mrs. Paige D. L'Hommedieu, New Brunswick, N. J.; Mrs. H. W. Parrott, Stratford, Conn.; Mrs. Gilbert Pingree, Grosse Pointe, Mich.; Mrs. Benjamin Riggs, Portland, Maine; Miss Ruth E. Rives, Buffalo, N. Y.; Mrs. Carl Grawn, 2nd Vice President of NOPHN; Mrs. I. Trumbull Wood, of Trenton, N. J. who was representing Council of Branches; Dr. Thomas D. Dublin, Executive Director of National Health Council and members of the NOPHN staff.

Among the many interesting items on the agenda was, a talk by Dr. Thomas D. Dublin, Executive Director of the National Health Council, on Development of Local Health Units. Miss Fillmore, in her report, discussed NOPHN finances and program and cited many important activities which NOPHN cannot undertake because of limited resources.

Following a report by Lillian Christensen on the activities of the Membership Committee, it was decided to make NOPHN membership promotion the Section's major project for the coming year.

LOAN FOLDER ON PRACTICAL NURSING

The Joint Committee on Practical Nurses and Auxiliary Workers in Nursing Services has compiled a loan folder on materials dealing with the preparation and use of practical nurses and auxiliary workers. Although no attempt has been made to bring together all published articles on these subjects, and although many viewpoints are included which are not necessarily representative of the philosophy of the Joint Committee, still it is expected that this compilation will prove valuable in providing background information useful in the formation of plans and programs in this field.

The loan folder is available to individuals and organizations upon request. The rental fee is $1 plus postage for each 2-week period, or part thereof, for which it is borrowed. Available from American Nurses' Association, 1790 Broadway, New York 19, attention of Joint Committee on Practical Nurses and Auxiliary Workers in Nursing Services.

POSTURE HANDBOOK REVISED

The handbook, *Posture and Nursing*, first published in 1942, has been completely rewritten by Jessie L. Stevenson in accordance with suggestions from representative nurses

and members of the Joint Council on Orthopedic Nursing The new edition is now available at 50 cents per copy from the Joint Orthopedic Nursing Advisory Service, 1790 Broadway, New York 19, New York.

EVALUATIVE CRITERIA REVIEWED

The NOPHN-NLNE Committee for the Study of Advanced Psychiatric Nursing and Mental Hygiene met on December 10 and 11 in New York City. The purpose was to review the tentative statement of descriptive criteria for the evaluation of programs in advanced psychiatric nursing and mental hygiene.

Committee members are: Elizabeth S. Bixler, chairman; Ruth Gilbert, Florence Harvey, Milenka Herc, Hazel Higbee, Eleanor Lewis, Mary Liston, Pearl Shalit, Ruth Taylor, Frances Thielbar, Mrs. Ethel Ginsburg, Mrs. Elizabeth Porter, Dr. F. W. Ossenfort, Agnes Gelinas and Dorothy Wilson. The study has been under the direction of Mary Schmitt, assisted by Sybil Pease.

AID TO PROFESSIONAL EDUCATION

To find out what medical, dental, and nursing educators want in the way of federal financial support of professional education, Federal Security Administrator Oscar R. Ewing recently held a series of conferences in Washington. Ruth Freeman represented NOPHN at the nursing group meeting on December 30-31.

TO COST STUDY STAFF

Mrs. Mary Elizabeth Bauhan, statistician, has joined the NOPHN staff to assist in completing the NOPHN Study of Costs in public health nursing. Mrs. Bauhan is on leave from the Association for the Aid of Crippled Children for the year 1949.

NOPHN FIELD SCHEDULE

Staff Member	*Place and Date*
Anna Fillmore	Washington, D.C.—Jan. 14-15
Lucy Blair	Denver and Boulder, Colo.—January
Mary T. Collins	Washington, D.C.—Jan. 7
	Springfield, Mass.—January 16
M. Olwen Davies	Washington, D.C.—Jan. 14
Elizabeth C. Stobo	Portland, Oregon,—Jan. 5-7
	Los Angeles, Cal.—Jan. 12-14
	San Francisco, Cal.—Jan. 19-21
	Dallas, Texas—Jan. 26-28
Louise M. Suchomel	Montclair, N. J.—Jan. 4
	Iowa City, Iowa—Jan. 16-21
	Omaha, Neb.—Jan. 24-25
Marie Swanson	New Orleans, La.—Jan. 3-14

December field trips not previously announced included: Hedwig Cohen—Somerset County, N. J.; Ruth Fisher—Mt. Desert, Portland, and Biddeford, Me.; Louise M. Suchomel—Washington, D. C.; and Marie Swanson—Trenton, N. J.

ABOUT PEOPLE YOU KNOW

Alta E. Dines, internationally known leader in the field of nursing and nursing education, retired on December 31 as director of the department of educational nursing of the Community Service Society, New York, N. Y. A pioneer in the family health movement in this country, Miss Dines had served the agency 25 years.

Dr. Morris B. Sanders has been appointed as the first Public Health Attaché to represent the United States abroad. He is assigned to the embassies at Paris, Brussels, and The Hague, with residence in Paris, to collect data on health, medical research, health insurance, and public health administration. . . . *Emilie Willms, R.N.* of the Near East Foundation has been honored with the War Service Medal from the Greek government for "invaluable and most efficient service" from 1939-41 as supervisor of the 7th Military Hospital in Athens. . . . The following appointments are reported from California: *Martha Adam* as chief of the Public Health Nursing Service of the San Mateo County Department of Public Health and Welfare; *Alice Hagelshaw* and *Dorothy Merwin,* as general public health nursing consultants with the California State Department of Health; *Helen M. Hallgren,* director of public health nursing with the newly organized Napa County Health Department; and *Ila Z. Moore,* director of nurses in the Sutter-Yuba Health Department. . . . *Lillian Bischoff,* now associate director of the Division of Public Health Nursing of the Georgia Health Department, was the only American member of a group that assisted the Ethiopian Red Cross in its reestablishment.

NEWS AND VIEWS

from far and near

ICN RELATIONS WITH WHO

The First World Health Assembly voted to allow non-governmental organizations to be brought into official relationship with the World Health Organization. One of the first such organizations to be received in the scheme is the International Council of Nurses. Privileges conferred upon the non-governmental organization members are: (1) the right to appoint a representative to participate, without vote, in its meetings or in those of conferences and committees, and to make statements of an expository nature (2) access to non-confidential documentation and such other documentation as the director-general may see fit to make available and (3) the right to submit memoranda to the director-general.

STUDENT ADMISSIONS IN 1948

More than 43,000 students entered schools of nursing throughout the country in 1948, according to Mildred Riese, chairman of the National Student Nurse Recruitment Committee of the American Hospital Association. The 43,373 students recruited represent an increase of nearly 5,000 over the 1947 total and 12,000 more than in 1946, and constitute the largest number of student nurses ever recruited during a peacetime year.

Miss Riese credited the increase in enrollment to the national student nurse recruitment campaigns conducted during the past two years by the American Hospital Association in cooperation with the Advertising Council and leading national nursing, health, and medical organizations.

NEW RECRUITMENT FILM

Highlights of a nurse's career from the day she enters the hospital school to the day she becomes a registered professional nurse are dramatized in the new RKO-Pathé short, *Girls In White*. A part of the *This is America* series, the documentary was made with the cooperation of the ANA.

"We hope every nurse in America will see this thrilling picture about our profession, its achievements and its problems," Pearl McIver, president of the ANA said after seeing the film. "If it is not showing in their neighborhood theatre, nurses should urge the theatre owner to get it from his local RKO exchange. He will like it, too, for it is a dramatic presentation of a career and a problem that is of the most vital concern to the well-being of the American people."

Girls In White traces the education of one girl, Betty Burns, from the time she enters the nursing school of a typical American hospital, very determined and probably a little frightened by the work ahead of her, to her graduation and decision to specialize in pediatrics.

ARC BROADENS NURSES' AIDE PROGRAM

The American Red Cross is planning to extend its program of training of volunteer nurses' aides. With the cooperation of the Boston Metropolitan Chapter, National Headquarters has undertaken a study of a revised course for nurses' aides which not only will train them for service in hospitals, as in the past, but will provide opportunity for training for service in public health agencies. The course is designed to meet the increasing needs for care of the aged and chronically ill, and to assist with care of patients when they leave the hospitals.

Another extension of the Volunteer Nurses' Aide Service, developed recently in conjunction with the Veterans Administration, is the provision of hospital facilities for on-the-job instruction following the preliminary course.

The Red Cross offers qualified nurses an opportunity to make a further contribution to their communities by serving as instructors for this program. Nurses who are interested are urged to notify their local Red Cross chapter.

HOME NURSING EXPERTS CONFER

Means of broadening and adapting the Home Nursing program to meet more adequately present-day community needs for home care of the sick were discussed at a conference of American Red Cross home nursing consultants in Washington during early November.

"Creative effort and excellence of service" were recognized as musts in a truly broad and effective Home Nursing program. Recommendations made by the Home Nursing staff members as a result of the 2-week conference will place emphasis on extending the program to reach a larger section of the American public, particularly in rural areas, with instruction in home care of the sick.

NATIONAL INVENTORY

A nation-wide inventory of professional nurses was launched in December to aid the National Security Resources Board in its task of mobilization planning.

At the request of NSRB, the inventory will be conducted by the ANA, which will work with the boards of nurse examiners of the 48 states in gathering data. ANA officers met in New York with representatives of the state boards to explain purposes of the survey.

Data tabulated will include ages, preparation, and employment status of all registered nurses in the United States. With this information, the medical division of NSRB will develop recommendations to the President for the distribution of nurses to meet military and civilian needs in the event of war.

"To compensate for the shortage of nurses that would be probable if a national emergency should develop," explained Ruth Freeman, chief of the nursing section of NSRB, "it is essential to maintain a current inventory of all qualified individuals. With careful planning, we should then be able to provide for the most effective utilization of the nation's nurses if the need should arise."

The information will be kept up-to-date through periodic checks with the state boards of nurse examiners, with whom professional nurses in most states renew their licenses at regular intervals.

NEW PSNA PRESIDENT

Mathilda Scheuer, educational director of the Visiting Nurse Society of Philadelphia, was recently unanimously elected president of the Pennsylvania SNA. Miss Scheuer is a graduate of the Mercy Hospital School of Nursing in Baltimore and had her public health nursing preparation at the Pennsylvania School of Social and Health Work. She also studied at Teachers College, Columbia University, and at Syracuse University. She was president of the Pennsylvania Organization for Public Health Nursing from 1939 to 1945 and has just completed a term as first vice president of the PSNA.

ICN CONGRESS IN JUNE

Assurances of a hearty welcome awaiting American nurses who will attend the ICN Congress in Sweden in June, come from Karin Elfverson, chairman of the Arrangements Committee. The Swedish Nurses' Association, through which accommodations are being made, trusts that the warm reception and the pleasure to be gained through attendance will compensate for the limited type of lodging, bathing, and eating facilities available for such a large meeting.

To secure accommodations all American nurses—whether or not they are making their travel arrangements independently—must apply for application forms to the official American travel agent, Kathleen T. Tuite, Travel Arrangements, 11 West 42nd Street, New York, N. Y.

● The sixteenth annual observance of Brotherhood Week will be held from February 20 to 27, 1949. It is sponsored by the National Conference of Christians and Jews, under the chairmanship of Nelson A. Rockefeller. In the words of President Harry S. Truman, the celebration comes at a time "when none can doubt the urgency of its reminder that men of all creeds and races are bound together in one common fate."

● Copies of *The Nation's Health—A Ten-Year Program*, Oscar Ewing's report to President Truman on the "possibilities for raising health levels" in this country, are available free of charge upon request to the Federal Security Agency, Washington 25, D.C.

OFFICIAL DIRECTORY OF PUBLIC HEALTH NURSING

A list of those holding executive positions in the Federal Government, in national organizations, and in states and territories; officers of state organizations for public health nursing, and executive secretaries of state nurses' associations.

Information as of December 1, 1948, unless otherwise stated.

National Organization for Public Health Nursing, Inc.
President, Ruth W. Hubbard, General Director, Visiting Nurse Society of Philadelphia, 1340 Lombard Street, Philadelphia 47, Pennsylvania
General Director, Anna Fillmore, 1790 Broadway, New York 19, N. Y.

American Association of Industrial Nurses
President, Mary Delehanty, Equitable Life Assurance Society, 393 7th Avenue, New York 1, N. Y.
Executive Secretary, Mrs. Gladys L. Dundore, Room 407, 654 Madison Avenue, New York 21, N. Y.

American Nurses' Association
President, Pearl McIver, Office of Public Health Nursing, U. S. Public Health Service, Federal Security Building S., Washington 25, D.C.
Executive Secretary, Ella G. Best, 1790 Broadway, New York 19, N. Y.

Association of Collegiate Schools of Nursing
President, Elizabeth S. Bixler, School of Nursing, Yale University, New Haven, Connecticut
Executive Secretary, Mrs. Dorothy R. Williams, 2063 Adelbert Road, Cleveland 6, Ohio

National Association of Colored Graduate Nurses, Inc.
President, Mrs. Alida C. Dailey, 171 Lincoln Street, Montclair, N. J.
Executive Secretary, Alma Vessells, 1790 Broadway, New York 19, N. Y.

National League of Nursing Education
President, Agnes Gelinas, 303 E. 20 Street, New York 3, N. Y.
Executive Secretary, Adelaide A. Mayo, 1790 Broadway, New York 19, N. Y.

National Association for Practical Nurse Education
654 Madison Avenue, New York 21, N. Y.
President, Ella M. Thompson
Secretary, Elisabeth C. Phillips

National Security Resources Board, Nursing Section
Chief, Ruth Freeman, Nursing Section, Medical Services Division, NSRB, Washington, D.C.

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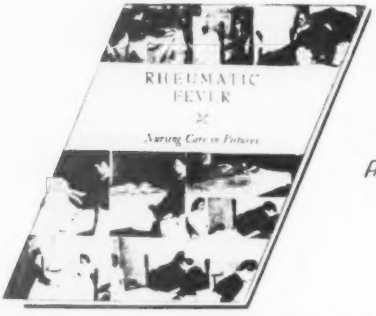

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[1] Nutrition in Diabetes, Nutrition Rev. 6:257 (Sept.) 1948.

[2] Diabetes and Arteriosclerosis in Youth, Editorial, J.A.M.A. *135*:1074 (Dec. 20) 1947.

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